Rehabilitation Service Referral Form

UNIVERSITY OF MINNESOTA
VETERINARY MEDICAL CENTER
1365 Gortner Ave, St. Paul, MN 55108

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Local: 612-626-8387 Toll Free: 800-258-6838 Fax: 612-624-8779

Date: _____

Client Name: _____ Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Name: _____ D.O.B.: _____

Breed: _____ Sex: _____ Color: _____ Weight: _____ kgs. / lbs.

Referring Veterinarian, please complete the following:

Referring Veterinarian Name: _____ Clinic: _____

Address: _____ City: _____ State: _____ Zip: _____

Program to which patient is being referred:

☐ Physical Rehabilitation ☐ Exercise / Conditioning

Reason for referral / Working Diagnosis: _____

History / Medical Condition (s): _____

Pertinent Diagnostics: _____

Treatments / Medications: _____

Other Information regarding this case: _____

As Referring Veterinarian, I understand that I remain the primary care provider.

Signed: _____ **Date**: _____