Allure
Integrated Pet Specialists

Date _____

VETERINARIAN REFERRAL FORM

REFERRAL INFORMATION

Primary Care Veterinarian _____ Clinic Name _____

Phone (____) ____ - _____ Fax (____) ____ - _____ Email _____

Primary Care Veterinarian's Cell Phone (Optional) (____) ____ - _____

SPECIALTY DEPARTMENT REQUESTED

☐ EMERGENCY ☐ SURGERY ☐ ACUPUNCTURE ☐ CHIROPRACTIC

☐ TCVM ☐ REHABILITATION ☐ NEUROLOGY (COMING JUNE 2021)

CLIENT / PATIENT INFORMATION

Owner Name _____ Co-Owner Name _____

Home Phone (___) ___ - _____ Cell Phone (___) ___ - ____ Email _____

Patient Name _____ Breed _____ DOB _____

Sex: Male Neutered Female Spayed Weight _____

MEDICAL INFORMATION

Reason for Referral / Primary Complaint: _____

_____

_____

Expectations for this Case: _____

_____

Precautions / Special Considerations: _____

_____

Additional Comments: _____

_____

FOR REHABILITATION ONLY:

In accordance with Texas Veterinary Board Rules, as the supervising Veterinarian, I have established a valid veterinarian/client/patient relationship and determined that rehabilitation will not likely be harmful to the patient.

_____ _____

Referring Veterinarian's Signature Date

☐ Ready to Start Rehab Now

☐ Begin Rehab After ___/____

Please have client bring hard copies of all records OR email records to info@allure.pet OR fax records to (210) 519-2989.