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 ☐ REHABILITATION ☐ FELINE MEDICINE

☐ TRADITIONAL CHINESE MEDICINE ☐ ACUPUNCTURE ☐ CHIROPRACTIC

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 Complain _____

_____

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.

_____ _____ ☐ Ready to Start Rehab Now

Referring Veterinarian's Signature Date ☐ 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.