



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/URGENT CARE   
  REHABILITATION   
  CHIROPRACTIC  
 TRADITIONAL CHINESE MEDICINE (HERBALS)   
  ACUPUNCTURE

## 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.