



Animal Rehabilitation Facility
8040 Fourth Street
Dexter, MI 48130

Phone: 734-253-2722
Fax: 734-253-2736
Email: K9RehabMI@gmail.com

Patient Referral Form

Referring Information:

Doctor's Name: _____
Hospital: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____

Client Information:

Client Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

Patient Information:

Name: _____
Breed: _____
Rabies Vx History: _____
D.O.B. _____
 Canine Feline
Sex: Male Neutered
 Female Spayed

Does this patient have a history of any of the following conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Blood Disorder: _____ |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Skin condition: _____ |
| <input type="checkbox"/> Heart Murmur/Arrhythmia | <input type="checkbox"/> Bloat/GDV | <input type="checkbox"/> Other: _____ |

History/Physical Findings: _____

Radiographs: _____

- Radiographs Enclosed (Disc) Radiographs Emailed Please Return Films

Current Treatments (include medications and dosages): _____

Diagnosis/Date and Type of Surgery (if applicable): _____

Special Requests/Comments: _____

Please be sure to include any surgical reports or patient discharge instructions with this report.