

# Rehabilitation Patient Referral Form



Circle City Veterinary Specialty and Emergency  
9650 Mayflower Park Dr.  
Carmel, IN 46032  
(317) 872-8387  
Fax: (317) 872-1964  
[www.circlecityvets.com](http://www.circlecityvets.com)

Referring Veterinarian: \_\_\_\_\_

Hospital Name: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Client Name: \_\_\_\_\_

Client Phone: ( ) \_\_\_\_\_

Patient Name: \_\_\_\_\_

Canine     Feline    Breed: \_\_\_\_\_

Sex:  M    F    MN    FS    Age: \_\_\_\_\_

Reason for Referral:

---

---

---

Previous Surgical Procedures:

---

---

---

Pertinent Medical History/ Pre-Existing Conditions:

**\*Please send a completed copy of patient's medical history prior to appointment.\***

---

---

---

Goals of Rehabilitation:

---

---

---

---

Restrictions:

---

---

\*Completion of this form authorizes evaluation and complimentary medicine and/or rehabilitation treatment for this patient. Clients seeking any other service will be redirected to the referring doctor or to another specialty within this hospital.

\_\_\_\_\_  
Referring DVM signature

\_\_\_\_\_  
Date