Coastal Carolina Veterinary Rehabilitation Referral

Date _____

1. **Veterinarian Information**

   Referring Dr. _____

   Phone numbers: Daytime _____ Evening _____ Cell _____

2. **Client Information**

   Name _____

   Address _____

   Phone _____

3. **Patient Information**

   Name _____ Breed _____ Sex _____

   Age _____ Weight _____

4. Veterinarian Diagnosis or Impression of the Problem:_____

   _____

5. Type of surgery performed _____

   Date performed _____

6. Current Medications: _____

   _____

7. Will the patient require overnight care? YES NO
   If Yes, will this care be provided by the ER or Rehab facility _____

8. Anticipated length of rehabilitation _____

9. Contraindications, therapy restrictions, or other medical issues of importance (seizures, heart disease, etc): _____

   _____

10. Please feel free to recommend or suggest rehabilitation modalities or treatments you believe may be helpful to this client: _____

Veterinarian Signature:_____ Date:_____

Please fax/send any pertinent information (medical history, surgical report) to
(843) 747-7920, ATTN: Rehab