OVC Fitness and Rehabilitation Service (FAR) Patient Referral

REFERRAL INFORMATION

REFERRING CLINICIAN:	EMAIL:	CONTACT #: FAX#:
PRIMARY CARE DVM: (if different from above)	EMAIL:	CONTACT#: FAX#:

OWNER'S NAME:	CONTACT #:

PATIENT'S NAME :	BREED:	DOB:	SEX:
CHIEF COMPLAINT OR DIAGNOSIS:			

HISTORY AND PHYSICAL EXAM FINDINGS:

RADIOGRAPHS TAKEN: YES NO **RADIOGRAPHS INCLUDED: YES NO**

DIAGNOSTIC TESTS PERFORMED:

- ○ CBC
- ○ Chemistry panel
- ○ Urinalysis
- ○ EMG
- ○ Biopsy
- ○ Other:__________

TEST RESULTS ATTACHED?: YES NO

OTHER CURRENT HEALTH PROBLEMS OR DIAGNOSIS:
1.
2.
3.
4.

CURRENT VACCINATION STATUS:
LAST RABIES VACCINE:
LAST DH2PPV VACCINE:

CURRENT THERAPY & MEDICATION(S)/SUPPLEMENTS:

SPECIAL REQUESTS / COMMENTS:

IF THE FOLLOWING ARE RECOMMENDED BY THE FAR TEAM, PLEASE INDICATE IF FAR TEAM CAN DISPENSE ON A SHORT TERM BASIS. IF BOXES ARE LEFT UNCHECKED, THE CLIENT WILL BE DIRECTED TO THEIR FAMILY VETERINARIAN TO REQUEST THESE ITEMS.

- ○ **PAIN MEDICATION (AS NEEDED)**
- ○ **NUTRTIONAL SUPPLEMENTS**
- ○ **PRESCRIPTION DIETS**

VETERINARIAN NAME:

SIGNATURE:

DATE:

CORRESPONDENCE REQUESTED VIA EMAIL , TELEPHONE, or FAX. ____________________________________

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