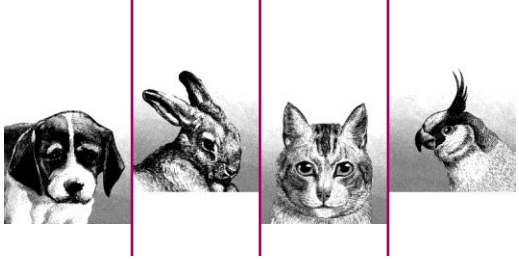
town centre veterinary hospital



REFERRAL FORM

Acupuncture/Chiropractic/Manual Therapy/Massage Therapy/Laser Therapy

Owner's Name: _____
Address: _____ City: _____ P/C: _____
Phone: (h) _____ (w) _____ (c) _____

Pet's Name: _____
Sex: M F MN FS Date of Birth: _____ Breed: _____
Colour: _____
Weight: _____

Diagnosis/Medical History:

_____
_____
_____
_____

Previous surgeries/procedures/injuries:

_____
_____
_____

Medications:

_____
_____
_____

Requested treatment: Acupuncture _____ Chiropractic/Manual Therapy _____Massage Therapy_____
Laser Therapy ___

All referrals require medical records be faxed or emailed to Town Centre Veterinary Hospital prior to the client's first appointment. Fax is 780-461-4775. Email is pet.care@towncentrevet.ca.

All Acupuncture referrals require a complete physical examination prior to the first acupuncture treatment. X-rays, blood work, or other diagnostic tests may be required depending on the condition being treated and on what has already been performed at the referring clinic. Please fax all results prior to the client's first visit.
All chiropractic/manual therapy referrals will require a complete physical examination and possibly x-rays at TCVH prior to the first chiropractic assessment. If x-rays have already been taken at your hospital, please send them with your client or email them so we can review them at or prior to the initial assessment.
All massage therapy referrals will require a physical examination at TCVH prior to the first massage session, but x-rays are not necessary.

Veterinarian's Name _____
Veterinarian's Signature _____
Hospital/Clinic _____
Date _____

1502 Lakewood Road West | Edmonton, Alberta, T6K 3J4 | T 780-496-9065 | F 780-461-4775 | E pet.care@towncentrevet.ca