Rehabilitation Service Referral Form

Four Paws Rehabilitation Center
Cassie Steidl, CVT, CCRP
4pawsrehabalexvet@gmail.com
710 3rd Ave. West
Alexandria, MN 56308
Phone: 320-815-0894
Fax: 320-762-8044

Client Name: _____ Phone:

Address: _____ City: _____ State: _____ Zip:

Email: _____ Patient Name: _____ D.O.B.

Breed: _____ Sex: _____ Color: _____ Weight: _____ lbs

Referring Veterinarian, please complete the following:

Referring Veterinarian Name: _____ Clinic:

Address: _____ City: _____ State:

Zip: _____ Email:

Please choose program below patient is being referred for:

❒ Physical Rehabilitation ❑ Exercise/Conditioning

Reason for Referral/ Working Diagnosis: _____

History/Medical Condition (s): _____

Diagnostics Completed:

Treatments/Medications:

Other important information regarding this case:

Our Facility requires Rabies DHPP and Bordetella vaccinations are current, please send updated records with this form.

As Referring Veterinarian, I understand that I remain the primary care provider.

Signed: **Date:**