# Rehabilitation Service Referral Form

**Four Paws Rehabilitation Center**
**Cassie Steidl, CVT, CCRP**
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710 3rd Ave. West
Alexandria, MN 56308
Phone: 320-815-0894
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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:_____________________**