



Kindness and Care for Animals®

REFERRAL FOR ANGELL PHYSICAL THERAPY SERVICES

Client:

Phone:

Patient:

Age/DOB:

Sex:  M  F

Altered?  Y  N

Breed:

Pertinent past medical history:

Diagnosis:

Medical/rehabilitation precautions:

Medications:

Diagnostic studies/results:

Type/date of surgery:

A comprehensive evaluation and appropriate treatment plan will be initiated unless more specific treatment goals are checked below.

- Reduce pain
- Improve range of motion
- Decrease swelling/inflammation
- Increase strength
- Enhance function and performance

- Increase flexibility
- Facilitate neurological return
- Improve conditioning and endurance
- Decrease weight
- Other (please specify)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Place of Business