angell

Kindness and Care for Animals™

REFERRAL FOR PHYSICAL REHABILITATION

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

PLEASE RETURN THIS SHEET ONLY TO ANGELL WEST REHAB (FAX 781-622-1410)