angell
Kindness and Care for Animals™

REFERRAL FOR PHYSICAL REHABILITATION

Client: Phone:

Patient: Age/DOB: Sex: ☐ M ☐ F Altered? ☐ Y ☐ N

Breed: Date of last rabies vaccine: Due date for next rabies vaccine:

Pertinent medical history:

Diagnosis:

Diagnostic studies/results:

Type/date of surgery:

Medications:

Medical/rehabilitation precautions:

Any history of:

- ☐ Cardiac disease
- ☐ Laryngeal paralysis
- ☐ Exertional dyspnea
- ☐ Other respiratory disease
- ☐ Dermal lesions
- ☐ Otitis externa
- ☐ Recent skin sutures or staples
- ☐ Food allergies

If yes to any of the above, please elaborate:

Specific treatment goals:

- ☐ 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 OR EMAIL PHYSICALREHAB@MSPCA.ORG)