

REFERRAL TO:

Tails of Rye Canine Rehab
675 Wallis Rd
Rye, NH 03870
603.379.2099 / 603.834.4497

www.tailsofrve.com
Kofitsas23@aol.com

Date: ____/____/____

Referring Veterinarian

Client

Name: _____
Clinic: _____
Phone: _____
Fax: _____

Name: _____
Address: _____
Phone: _____

Patient Information

Name: _____
Birthdate: _____
Breed: _____ Sex: _____ Neutered _____

Referred for/diagnosis:

Pertinent Information (pre-existing conditions, prognosis, precautions, etc.)

Services Requested:

Goals of Rehab:

- Physical Rehab Assessment/Evaluation
- Hydro treadmill
- Aquatic therapy
- Massage/Myofascial release
- Range of motion
- Neuromuscular re-education
- Education – home program
- Strengthening
- Adaptive equipment
- Ultrasound
- Electrical-stimulation

- Restore range of motion
- Improve limb function
- Improve strength
- Improve conditioning
- Improve owner understanding of recovery
- Weight reduction
- Improve overall function
- Progress report: ____ mail ____ verbal (call)

Please send me additional referral forms. Quantity requested: _____

Please send me additional brochures. Quantity requested: _____

DVM/ Signature _____