



**DOGS IN MOTION**  
**IN HOME CANINE REHABILITATION & WELLNESS**  
**Patti Triola, PT, CCRT**



Website: [www.dogsinmotion.net](http://www.dogsinmotion.net)

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**REFERRAL FORM**

Veterinarian / Surgeon: \_\_\_\_\_

Client's Name: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Primary Veterinarian (if different from above): \_\_\_\_\_

Facility: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Dog's Name: \_\_\_\_\_ Breed: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Spayed / Neutered: \_\_\_\_\_ Onset of condition: \_\_\_\_\_

Past Medical History: \_\_\_\_\_

- The date that this canine can safely begin canine rehab: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Any restrictions or guidelines you would like followed (including weight bearing and range of motion): \_\_\_\_\_
- Next Veterinarian / Surgeon follow-up appointment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Please either complete the section below OR attach referral letter or medical records.**

Summary of any tests (x-ray, CT, myelogram, etc.) performed: \_\_\_\_\_

Summary of pre-op evaluation including diagnosis: \_\_\_\_\_

Surgical procedure performed, date, prognosis, and post-op medications: \_\_\_\_\_

**Please fax this signed referral to 847-949-8456.**

I authorize Dogs in Motion, Canine Rehabilitation & Wellness to evaluate and treat on the above stated client for rehabilitation following any guidelines or restrictions that I have established.

\_\_\_\_\_  
Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

**Thank you for choosing Dogs in Motion**