

VCA Veterinary Specialists of CT

993 North Main Street, West Hartford, CT 06117

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Rehabilitation Services Referral Form

Referring Veterinarian: _____ Referring Hospital: _____

Phone: _____ Fax: _____ E-Mail: _____

Address _____ City _____ State _____ Zip _____

Client Information:

Owners Name: _____ Contact Phone Number: _____

E-Mail: _____

Address _____ City _____ State _____ Zip _____

Pets Name: _____ Breed: _____ Color: _____

Weight: _____ DOB/Age: _____ Sex: _____

Medical Information:

Diagnosis (required): _____

Reason for referral: _____

Current Treatments and Medications: _____

Please select the rehabilitation modalities of interest:

- EMS/TENS Land Treadmill Low Level Laser Therapy Therapeutic Ultrasound
 Pulsed Electromagnetic Field (PEMFt)

As the referring veterinarian, I, _____ (print name), understand that I remain the primary care provider for this patient. I acknowledge that the rehabilitation treatment plan will be generated based on the definitive diagnosis provided above.

Signature: _____ Date: _____