Commonwealth Animal Hospital
1058 N. College St. 859-734-2245 office
Harrodsburg, KY 40330 859-734-5071 fax
R. Paul Bosse, DVM Tammy Mobley

REHABILITATION REFERRAL FORM

Today's Date: _____ CAH Appointment Date: _____

Client Name: _____ Title: Mr. Mrs. Ms. _____ (other)

Client Contact Number: _____ Best Time To Call: _____

Client Email: _____ Clinic Fax: _____

Pet's Name: _____ Breed: _____

DOB or Age: _____ Sex (circle one): M M/N F F/S

Vaccine Status (dates given):
_____ **DHLPP**
_____ **Bordetella**
_____ **Canine Influenza (H3N2)**
_____ **Rabies**

Reason for Referral/ Primary Concerns/ Problem History:

_____

_____

Previous Treatment/Tests/Procedures (include copy of medical records):

_____

_____

Requested Treatments/Modalities:

☐ Treat per protocol established by CCRP (Certified Canine Rehabilitation Practitioner) in training

and/or

Specific Requests:
☐ Therapeutic strengthening exercises
☐ Passive range of motion
☐ Therapeutic Class IV Laser
☐ Massage
☐ Underwater Treadmill

Outcome anticipated by referring veterinarian:

_____
_____
_____

_____
Signature of Veterinarian

Outcome anticipated by Owner:

_____
_____
_____

_____
Date