WOOF! PET WELLNESS RESORT- THERAPEUTICS

684459 Oxford 2, Woodstock Ontario, N4S 7V7 (226) 228-8771 tracy@woofpetresort.com

VETERINARY REFERRAL FORM

Client: ______________________________ **Patient:** _______________________

Breed: __________________ **Sex:** _______ **Age:** ________ **Weight:** _________

Referring veterinarian/clinic: ____

Clinical condition: _____________________________ **Onset/Sx date:** _________

Special Instructions/Precautions:____

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Medications:

Frequency and duration: _________ **Times per day for** ____________ **days.**

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Please turn over fill out and choose the suggested treatment plan you would like.

Plan: **Evaluate and Treat ___**

Treatments: **Frequency:**

- **Ultrasound ___** **________ a week**
- **Hydrotherapy ___** **________**
- **Massage ___** **________**
- **Passive Range of Motion ___** **________**
- **Laser ___** **________**
- **Pulse Magnetic Field Therapy ___** **________**
- **Ground work- muscle strengthening** **________**

Other: ______________________

I, (please print name) ________________________certify my client listed above is in my care, and I give consent to the treatment of this animal with Woof! Pet Wellness Resort.

DVM Signature: ____

****WE CUSTOMIZE EACH PROGRAM PLAN ALONG SIDE YOUR VETERINARY CARE PROFESSIONALS TO SUIT YOUR DOG'S INDIVIDUAL NEEDS** Please note that the services offered are not a substitute for Veterinary Care.**