



LAURELWOOD VETERINARY HOSPITAL  
REHABILITATION REFERRAL

515 BENJAMIN ROAD  
WATERLOO, ONTARIO • N2J 3Z4  
PHONE: 519-699-0875  
FAX: 519-699-0430  
www.laurelwoodvets.ca

Date:

Pet Name:

Owner Name:

Age:

Address:

Sex:

Phone Number:

Breed:

Email Address:

Vaccination Status:

Use/Activity of Pet:

Veterinary Clinic and Referring Veterinarian:

Clinic Phone Number:

Clinic Email Address:

**What is the presenting problem?**

- |   |                                       |   |  |                                     |
|---|---------------------------------------|---|--|-------------------------------------|
| <input type="checkbox"/> Had surgery: _____ | <input type="checkbox"/> Limping      | <input type="checkbox"/> Stiff                | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Weakness           | <input type="checkbox"/> Painful      | <input type="checkbox"/> Yelps when picked up | <input type="checkbox"/> Won't lift/wag tail |                                     |
| <input type="checkbox"/> Senior pet care    | <input type="checkbox"/> Other: _____ |   |  |                                     |

**Location of problem?**

**How long has problem been present?**

**Is it improving or worsening?**

**Is it worse or better with activity?**

**Is it worse or better after rest?**

**Any known injury?**

- Previous surgery? \_\_\_\_\_  Fell down stairs  Slipped  Hard play  
 Dog fight  Agility  Woke up with it  Unknown  Other: \_\_\_\_\_

**Current medications:**

**Have radiographs been taken?**

**Has the patient recieved rehabilitation/physiotherapy before? If so, from where?**

**Does the patient receive any other therapeutic treatment?**

- Massage therapy  
 Laser therapy  
 Hydrotherapy  
 Veterinary Spinal Manipulation Therapy

**Does the patient have any food allergies?**

- No  
 Yes: \_\_\_\_\_