VSMT REFERRAL FORM

Laurelwood Veterinary Hospital

Please email to
info@laurelwoodvets.ca
or fax to 519-699-0430

Date:

Pet's Name:
Age:
Sex:
Breed:
Use/Activity of Pet:

Owner's Name:
Address:
Phone Nulmber:
Email Address:
How were you referred?

I confirm that my pet is concurrently being cared for by our family veterinarian.
Family Veterinarian:
Phone number:
Email Address:

What is the presenting problem?
☐ Stiff ☐ Limping ☐ Dragging foot ☐ Weakness
☐ Painful ☐ Not jumping ☐ Walks sideways
☐ Won't do stairs ☐ Yelps when picked up ☐ Won't lift/wag tail
☐ Other: _____

Location of problem?

How long has it been present?

Is it improving or worsening?
Better or worse with activity?
Better or worse after rest?

Any known injury?
☐ Unknown ☐ Hard play ☐ Fell down stairs ☐ Agility
☐ Woke up with it ☐ Past surgery ☐ Dog fight
☐ Other: _____

What medications or supplements is your pet on?

Has your pet had x-rays?

Has your pet had a veterinary spinal manipulation therapy or chiropractic treatment in the past?

Does your pet receive any of the following care?
☐ Massage therapy
☐ Rehabilitation/physiotherapy
☐ Hydrotherapy