



**P.A.W.S. Companion Animal Rehabilitation and Exercise Services
Veterinary Referral Form**

CLIENT INFORMATION			
OWNER NAME:		SPOUSE/CO-OWNER:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:		ALT. PHONE:	
EMAIL ADDRESS:		EMERGENCY CONTACT & PHONE NUMBER:	
PATIENT INFORMATION			
PET'S NAME:		AGE/DOB:	
PLEASE CHOOSE:		WEIGHT:	
BREED:	SPECIES:	COLOR:	
REFERRING VETERINARIAN INFORMATION			
CLINIC NAME:		VETERINARIAN NAME:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:		FAX NUMBER:	
EMAIL ADDRESS:			
I would like to be updated on the patient's progress via:		Email	Fax Phone
PATIENT MEDICAL HISTORY			
PREVIOUS MEDICAL HISTORY:			
CHRONIC CONDITIONS:			
PRESUMPTIVE DIAGNOSIS AND DATE OF INJURY OR SURGERY:			
MEDICATIONS AND SUPPLEMENTS INCLUDING DOSE AND FREQUENCY:			
VACCINATION HISTORY INCLUDING DATE OF LAST RABIES VACCINE:			

SIGNATURE OF REFERRING VETERINARIAN:

DATE:

*PRIOR TO THE INITIAL APPOINTMENT, PLEASE SEND P.A.W.S. ANY RECENT LAB WORK
AND MEDICAL RECORDS, INCLUDING SURGERY REPORTS AND IMAGING STUDIES*