



## Veterinary Chiropractic and Rehabilitation Clinic

4604 Fuqua St.

Houston, TX 77048

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Fax: (713) 991-9503

[www.vetchiroandrehab.com](http://www.vetchiroandrehab.com)

## VETERINARIAN REFERRAL FORM

DATE: \_\_\_\_\_

### Please Mark Status of Appointment:

- Immediately
- This Week
- Non-Emergency

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*Please Fax completed form to (713)-991-9503 or submit via email to [vcrcinfo@vetchiroandrehab.com](mailto:vcrcinfo@vetchiroandrehab.com)*

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REFERRING DR: \_\_\_\_\_ CLINIC NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

### CLIENT/PATIENT INFORMATION:

OWNER NAME: \_\_\_\_\_ CO-OWNER: \_\_\_\_\_

PHONE (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

PET NAME: \_\_\_\_\_ BREED: \_\_\_\_\_

SEX: MALE OR FEMALE    SPAYED OR NEUTERED    AGE/DOB: \_\_\_\_\_    WEIGHT: \_\_\_\_\_

### MEDICAL RECORDS, PERTINENT LABWORK AND RADIOGRAPHS

Have radiographs been taken? YES OR NO      Date of Study: \_\_\_\_\_

Medical records, lab work, and or radiographs: FAXED or EMAILED    OTHER: \_\_\_\_\_

Brief History & Primary Complaint: \_\_\_\_\_

Tentative Diagnosis: \_\_\_\_\_

Referring Veterinarian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_