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# VETERINARY REFERRAL CONSENT FORM

PATIENT'S NAME: LAST NAME:

OWNER'S NAME: PHONE NUMBER:

PRESENTING COMPLAINT/DIAGNOSIS/SURGERY:

LIST OR ATTACH PATIENT REPORT/DIAGNOSTICS PERTAINING TO CONDITION:

ADDITIONAL MEDICAL CONDITIONS/COMMENTS:

REFERRING VETERINARIAN'S NAME:

REFERRING VETERINARY HOSPITAL:

By signing this document, the above veterinarian consents to rehabilitation being performed on the patient listed above. The above veterinarian is aware that all therapies will be provided and/or supervised under the direct supervision of a Certified Rehabilitation Practitioner. Four Paws does not solicit or have any association with surrounding veterinary hospitals.

VETERINARY SIGNATURE: DATE:

**Please email or fax consent/information to: info@fourpawsrehab.ca or 416 368 5084**