



REFERRAL FOR FLOWDOG SERVICES

Client: _____ Phone: _____
Patient: _____ Age/DOB: _____ Sex: M F Altered? Y N

Breed: _____

Pertinent past medical history: _____

Diagnosis: _____

Medical/rehabilitation precautions: _____

Medications: _____

Diagnostic studies/results: _____

Type/date of surgery: _____

A comprehensive evaluation and appropriate treatment plan will be initiated unless more specific treatment goals are checked below.

- | | |
|-----------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Reduce pain | <input type="checkbox"/> Increase flexibility |
| <input type="checkbox"/> Improve range of motion | <input type="checkbox"/> Facilitate neurological return |
| <input type="checkbox"/> Decrease swelling/inflammation | <input type="checkbox"/> Improve conditioning and endurance |
| <input type="checkbox"/> Increase strength | <input type="checkbox"/> Decrease weight |
| <input type="checkbox"/> Enhance function and performance | <input type="checkbox"/> Other (please specify) |

Signature

Date

Print Name

Place of Business