

Canine Aquatic Center Vet Referral Form

Veterinarian Information:

Veterinarian: _____ Hospital: _____

Phone: _____ Fax: _____

Email: _____

How would you like to receive patient updates? _____

Owner/Guardian Information:

Client Name: _____

Address: _____ City/State/Zip: _____

Cell Phone: _____ Home Phone: _____

Canine Information and History:

Dog's Name: _____ Age: _____ Breed: _____

Weight: _____ Gender: _____ Spayed or Neutered? _____ Yes _____ No

Diagnoses / Chief Complaints: _____

History / Treatments / Current Medications & Dosages: _____

Rehabilitation Goals: _____

Completion of this form authorizes Canine Aquatic Center to evaluate and treat the above referred patient. As the Referring Veterinarian, I understand that I remain the primary care provider. Clients seeking any other services will be redirected to the Referring Veterinarian.

I acknowledge that aquatic exercise (swimming) is a form of cardiovascular exercise and that swimming is currently appropriate for this animal.

Veterinarian Signature: _____ Date: _____

****Please send vaccination history if available along with referral** Thank you so much!**

