



Referral To: Petworks K9 Rehab & Fitness Referral Services

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Referring Veterinarian

Name: _____
Clinic: _____
Address: _____
Phone: _____
Fax:(to which progress reports will be sent)

Client

Name: _____
Address: _____
Phone: _____

Pet

Name: _____
DOB: _____ Breed _____

History

Primary Diagnosis/Surgery done:

Current medications:

Reason for Referral:

Musculoskeletal / arthritis
Post Operative rehab
Neurological
Part of Obesity management program

Fitting / training is use of assistive device
(ie. slings, ramps or special order cart)
Fun Swim/ Fitness
Other _____

Goal of Treatment:

Special considerations or precautions/other medical concerns: _____

Date of next scheduled progress examination with the patient's veterinarian: _____

Please contact client to arrange appointment

Client will call to arrange appointment

Veterinarian Signature: _____ **Date:** _____

Please send more: referral forms information brochures