Western Veterinary Clinic

25190 State Road 2 • South Bend, IN • 46619
Phone: (574) 234-3098 • Fax: (574) 287-3835 • info@westernvet.com

Date: _____

Chiropractic/Acupuncture Referral Request

Referring Veterinarian: _____ **Referring Veterinary Clinic:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Patient Information

Name: _____ **Species:** ❑ Dog ❑ Cat ❑ Other _____

Sex: ❑ Male ❑ Neutered ❑ Female ❑ Spayed **Breed:**_____ **Color:**_____ **Age:** _____

Owner Information

First Name:_____ **Last Name**:_____

Home Phone:_____ **Work/Cellular Phone**:_____ **Emergency Phone:** _____

Street Address: _____

City: _____ **State:** _____ **County:**_____ **Zip:**_____

Spouse/Alt Contact: _____ **Relation:**_____ **Phone:**_____

Reason for Referral/Diagnosis

Differential Diagnosis: _____

History:

Lab and Radiographic Findings: ❑ X-rays ❑ Blood Work ❑ EKG ❑ Other _____
History & digital X-rays may be emailed to info@westernvet.com

Previous Treatment/Surgery:

Please tell the client the following:

- Continue regular medications
- Payment is due when services rendered. We accept cash, debit, credit card, CareCredit, and check.

Please fax or email this referral form as soon a possible prior to the initial visit.
Thank you for allowing us to partner with you to help improve your patient's quality of life.