Western Veterinary Clinic

25190 State Road 2, South Bend, IN 46619
Phone: (574) 234-3098 Fax: (574) 287-3835

Consultation Date: _________

Consultation Time: _________

Referral Request: Physical Therapy

Referring Veterinarian: _______________________________ **Referring Veterinary Clinic:** _______________________

Phone: __________________________ **Fax:** ___________________________

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: ____

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Medical history (include surgeries, medications, pre-existing conditions, etc): ______________________________

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Diagnostics performed: ❑ **X-rays** ❑ **Blood Work** ❑ **Other** ____

Please fax or email history to info@westernvet.com

Additional information (allergies, temperament, unrelated conditions, etc): _________________________________

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Please tell the client the following:

- Payment is due when services rendered. We accept cash, debit, credit card, CareCredit.
- Duration of the appointment could last between 30-60min.