Animal Name: Date:

Professional Referral Form

Pivotal Animal Rehabilitation requires Veterinary authorisation and an attachment of required information (Clinical History and Diagnostic Images). Please complete and send to pivotaltherapy@outlook.com.

CLIENT INFORMATION (*provided to Pivotal Animal Rehabilitation at registration*).

Client Forename: _____ Animal Name: _____
Client Surname: _____ Species: Canine
Address: _____ Breed: _____
_____ Age: _____
_____ Neutered: ☐ YES ☐ NO
Contact No.: _____ Insurance: _____
Email: _____

CURRENT VET CLINIC (*the clinic that referred to Pivotal Animal Rehabilitation*).

Referring Clinic: _____ Referring Vet: _____
Clinic Address: _____ Contact No: _____
_____ Full Clinical History: ☐ YES ☐ NO
_____ Diagnostic Images: ☐ YES ☐ NO
Clinic Email: _____
Referral Reason: _____
Other Conditions: _____

Referring Vet Sign: _____

PREVIOUS VET HISTORY *(additional clinical histories from other vets, please include the relevant information)*.

Previous Clinic: _____ Previous Vet: _____
Clinic Address: _____ Clinic Contact No: _____
_____ Clinical History: ☐ YES ☐ NO
_____ Diagnostic Images: ☐ YES ☐ NO
Clinic Email: _____
Noted Conditions _____

OWNER CONSENT (*to use and store information provided*).

Client, this information will not be shared unless you have authorised or requested. Please print your name and sign below before attending initial appointment. See the Terms & Conditions document for further information on how your data is stored and handled.

Print Name: _____ Date: _____

Signature: _____

Animal Name: Date:

Supporting Case Information

Referring clinic, please complete this form to help direct the treatment as you would prefer. Please add anything you would like performed and what treatment/diagnostic plans you are considering.

VETERINARY TREATMENT SUMMARY (Referring clinic please complete)

Date first noticed: _____ Diagnosis: _____

Key Findings: _____

Treatment provided: _____

Treatment Plan: _____

(Diagnostics, bloods etc.)

Review progress: ☐ YES ☐ NO

If yes, when: _____

REHABILITATION TREATMENT: (*What treatment would you prefer?*)

What would you like to achieve? _____

What treatment do you authorise?

Massage	☐
Laser	☐
Pulsed Electromagnetic Therapy	☐
Therapeutic Ultrasound	☐
TENs and NMES	☐
Hydrotherapy	☐
Remedial Exercises	☐
All of above	☐

Any precautions or things to avoid: _____

ADDITIONAL INFORMATION (*Please fill if known, leave blank if not noted in history*)

Vaccinated (including Kennel Cough)	☐ YES	☐ NO
Worming (Up to date with tapeworm)	☐ YES	☐ NO
Behavioural issues	☐ YES	☐ NO

If yes, please explain: _____

Skin Allergies: _____

Gastrointestinal illnesses: _____

Other issues/concerns: _____