Nickel City Animal Hospital Rehabilitation Referral Form

473 Niagara St. Buffalo, NY 14201 • (716)847-1000 • (716)847-1004 Fax • ncahtechs@gmail.com

Client: _____ Patient: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Date of Referral: _____
Email: _____
Breed: _____ Sex: _____ Age: _____

Referring Veterinary Hospital: _____ Phone: _____
Referring Veterinarian: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____

Primary Veterinarian Hospital (if not referring vet): _____

Clinical Condition/Reason for referral: _____
_____

Pre-existing conditions: _____

Onset/date of surgery: _____

Special instructions/precautions: _____
_____

Current Medications: _____
_____

Vaccinations up to date: _____
If not up to date, why? _____

A treatment plan will be created for each individual patient. These treatments could include but are not limited to:

**acupuncture, electro acupuncture, massage therapy, electrical stimulation, hydrotherapy, cryotherapy, hot packs, gait training, joint mobilization, in hospital/at home therapeutic exercises and much more.

If there are any reasons why this patient should not perform any of the above conditions, please specify:
_____

**Please send a copy of all records, radiographs and bloodwork that have been performed before upcoming appointment.

Completion of this form authorizes Nickel City Animal Hospital 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.

Preferred method of contact:
- ☐ Email
- ☐ Fax
- ☐ Mail

Referring Veterinarian Signature: _____

Date: _____

NICKEL CITY ANIMAL HOSPITAL