 **K9 Mobile Rehab**

*At home care, where your pet is most comfortable*

Cherie Parisi CVT CCRP

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Referral for Rehabilitation

Client:

Patient:

Age/DOB:

Sex:

Breed:

Diagnosis/Diagnostic results:

Medications:

Type/Date of surgery:

Past medical history if applicable:

\_\_\_ Owner requested rehab

A rehab evaluation and appropriate treatment plan will be initiated unless more specific treatment goals are checked below.

\_\_\_Reduce pain \_\_\_ Improve range of motion/function

\_\_\_Increase strength \_\_\_Decrease swelling/inflammation \_\_\_Facilitate neurological return \_\_\_Improve conditioning and endurance \_\_\_Decrease weight Other (please specify):

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Business \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_