



Animal Alternative Medicine and Rehabilitation Center

@Sunshine Animal Hospital
2807 Gulf to Bay Drive
Clearwater, FL 33759
727-687-8435

Referral Form

Referring Veterinarian/Hospital: _____
Hospital telephone #: _____ Fax #: _____
RDVM email: _____ Preferred Contact (Circle): Call/Fax/Email
Client Name: _____
Client home phone #: _____ Cell #: _____ Work #: _____
Client address: _____ City: _____ Zip: _____
Patient's name: _____ Species: _____
Breed: _____ Sex: _____ DOB: _____ Weight: _____ BCS: _____
Current Medications and Dose: _____

Patient history, diagnosis, and clinical condition: _____

_____ Onset/Sx Date: _____
Radiographs/Lab Work Performed: _____

Special Instructions/Precautions: _____

Referral Expectations (ie rehab, acupuncture, herbal tx, medical manip): _____

PLEASE SEND LAB WORK, RADIOGRAPHS, AND VACCINATION/INTESTINAL PARASITE EXAM HISTORY VIA FAX OR EMAIL WITH THIS REFERRAL FORM.

We will contact you via your preferred method following the initial evaluation. The standard policy of Animal Alternative Medicine and Rehabilitation Center is to send clients back to the referring veterinarian for continued care following alternative therapy procedures unless otherwise requested. Please indicate any other/additional expectations or requests you may have of us below:

PLEASE FAX OR EMAIL TO: **Animal Alternative Medicine and Rehabilitation Center**
FAX: 727-724-1031 EMAIL: ANIMALALTERNATIVECLEARWATER@YAHOO.COM