Info@opvancouver.com

604-864-1684

Susan Calverlev DVM CCRT

Patient referral information:

Owner information:	Veterinary information:
Client name:	**Referring Veterinarian:**
Address:	**Practice name:**
City: **Prov:**	**Address:**
Postal code:	**City:** **Prov:**
Home:	**Postal code:**
Cell:	**Telephone:**
Email:	**Fax:**
	Email:

Patient information:

Patient name: **Species:** **Canine** **Feline**

DOB: **Weight:** **Sex:**

Breed: **Laterality:** **LF** **RF** **LH** **RH** **Bilateral**

Case information:

Diagnosis:

Pertinent medical history:

How long has injury been present?

Therapeutic goals of orthotic/prosthetic solution:

☐I am able to provide follow up care including rehabilitation therapy.

☐I am unable to provide follow up care and would like OrthoPets Vancouver to refer this case for rehabilitation therapy and follow up or would like OrthoPets Vancouver to recommend exercises.

DVM signature: Date: