

Chiropractic Referral Service

Referring Doctor: _____ Date _____

Referring Practice: _____

Client Name: _____

Pet Name: _____

Dog Cat Horse

Pet Disposition: Relaxed and friendly 1 2 3 4 5 Aggressive or difficult to restrain

Working Diagnosis: _____

Most recent radiographs were taken: _____

Please send all radiographs either by mail ASAP (if time permits), email to chiro@ciceroanimalclinic.com, or send with owner if necessary

Has CT or MR imaging been performed? No Yes Date _____

List most recent blood work:

Please fax copies of blood work along with last year of chart to (315)-699-0944.

Current Medications, doses and intervals:

Relevant past medications, doses and intervals:

List any adverse medication events: _____

Please fax the last year of the patient's chart to (315) 699-0944

Dr. Gilbraith will contact you once form is received and reviewed.