



Rehabilitation Referral Form

21 Olt Avenue
Pekin, IL 61554
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Fax: 309-346-5398
www.pekinveterinaryclinic.com

Date: _____

Referring Veterinarian

Name: _____

Hospital: _____

Address: _____

Phone: _____

Fax: _____

Client

Name: _____

Address: _____

Phone: _____

Pet's Information

Name: _____

Date of Birth: _____

Breed: _____

Sex: _____

Reason for Referral:

Medical History: (Include duration of condition, surgeries, past/present medications and results of therapy, etc)

Related Diagnostics & Results: (please attach lab results and related records)

Additional Information: (Allergies, pre existing/unrelated conditions, etc)

DVM Signature: _____ Date: _____