# ARFIT REHABILITATION REFERRAL FORM

Vet Name: ___________________________________________

Clinic:_______________________________________________

Owner Name: ________________________________________

Dog Name:___________________________________________

Diagnosis:___________________________________________

Precautions:_________________________________________

**Services Recommended:**

- ☐ Range of Motion
- ☐ Cold Laser
- ☐ Therapeutic Exercise
- ☐ Restore range of motion
- ☐ Improve strength/condition
- ☐ Decrease arthritis pain/discomfort
- ☐ Joint Mobilization / Massage
- ☐ Dry Needling
- ☐ Education
- ☐ Improve function
- ☐ Weight reduction
- ☐ Owner knowledge/understanding

Vet/DVM Signature: ____________________________________

Vet/DVM Phone No:_____________________________________

Desired Outcome of Treatment:___________________________

Date:_________________________________________________

Arfit Dog Rehab / Fitness
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