



Rehabilitation & Pain Management Department  
Central Houston Animal Hospital  
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Rehabilitation and Pain Management Referral

Referral Information:

- Veterinarian Name: \_\_\_\_\_
- Hospital Name: \_\_\_\_\_
- Veterinarian Number: \_\_\_\_\_
- Veterinarian Email: \_\_\_\_\_

Client Information:

- Name: \_\_\_\_\_
- Number: \_\_\_\_\_
- Email: \_\_\_\_\_

Patient Information:

- Patient name: \_\_\_\_\_
- Breed: \_\_\_\_\_
- Age/Date of birth: \_\_\_\_\_
- Fractious or infectious: \_\_\_\_\_

Reason for referral (patient must have a diagnosis): \_\_\_\_\_

Goals/expectations: \_\_\_\_\_

\_\_\_\_\_

Approved date to start rehab: \_\_\_\_\_

If additional diagnostics are recommended, how would you like us to proceed:

\_\_\_\_ Please refer back for diagnostics      \_\_\_\_ Please proceed with internal diagnostics

***Please provide all medical records pertaining to patient being referred for rehabilitation and all diagnostics that have been completed.***

In accordance with Texas Veterinary Board Rules, as the supervising Veterinarian, I have established a valid veterinarian/client/patient relationship and have determined that rehabilitation will not likely be harmful to this patient.

DVM Signature: \_\_\_\_\_ Date: \_\_\_\_\_