The Dog Paddle
Canine Hydrotherapy Centre

REFERRAL FORM

Vet to complete

Patient Name: _____ Breed: _____ Age: _____ Sex: _____
Owner's Name: _____
Address: _____ Suburb: _____
Phone: _____ Email: _____
Referring Veterinary Clinic: _____Phone: _____
Email: _____ Referring Vet: _____

Primary reason for referral: _____

Diagnosis / Current treatment: _____
_____
_____
_____
_____
_____
_____
_____

Precautions / Contraindications

Other orthopaedic/muscular concerns ☐
Cardiac/respiratory disease ☐
Recent infections ☐
Faecal incontinence ☐
Chemotherapy treatment ☐

Medication(s):_____
_____
_____
Date and type of last vaccination: _____
_____

_____ _____ _____
Vet Name Signature Date

Email to: greencross.oceanreef@greencrossvet.com.au
Greencross Vets Ocean Reef
94 Caridean Street, Heathridge WA 6027
Phone (08) 9401 0663