# Augustak9trails

Canine Hydrotherapy & Trail Adventures

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Date_____

**Veterinarian** _____ **Client Name** _____

Practice _____ Phone _____

Phone _____ Address _____

E-Mail _____ _____

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**Patient Information:**

Name _____ Date of Birth _____ Sex _____ Breed _____

**Primary Diagnosis** _____

_____

**Medical Conditions** _____

_____

Current Medications

- _____
- _____
- _____

**Reason For Referral**

- ◯ Post-Operative Rehabilitation
- ◯ Post-Injury Rehabilitation
- ◯ Neurological
- ◯ Arthritis
- ◯ Geriatric Support
- ◯ Weight Loss
- ◯ Conditioning

**Special Considerations/ Precautions** _____

_____

**Veterinarian Signature** _____ **Date** _____

**Please remit this form by EMAIL info@augustak9trails.com or have the client bring to first appointment.**