

Therapy Referral Form

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Date:	Urgent or Routine:		
Owner Address:			
Owner Telephone:			
Animal's Name:		Use:	
Breed:	Height:		Sex:
Referring Vet Practice:			
Referring Vet Email:			
Please tick service required			
Physiotherapy Assessment/Rehab Programme with Chartered Physiotherapist ACPAT(A)			
Water Treadmill		Dry Treadmill	
Box Rest		Hand Walking _	mins per day
Electrotherapy; US/Laser/MM Stim			
Inpatient		Outpatient	
Other			
Diagnosis/Injury:			
Treatment:			
Past Medical History:			
Medication:			
Previous Level of Fitness:			
Insured Y/N:		Insurance company:	
Claiming Y/N:			

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