Dr. Katie S. King, D.C.

Certified Veterinary Chiropractor

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Please print and bring this referral form with you at the time of your appointment

Pet's Name: ____________________

Pet's Breed: ____________________ Age: __________ Sex: ☐ M ☐ F

Approximate Weight: __________ Canine: ☐ Feline: ☐ Other: __________

Client Information

Last Name: ____________________ First Name: ____________________

Telephone Number: (____) __________ Cellular Number: (____) __________

Address: ____________________

City: ____________________ State: ______ Zip Code: __________

Referring DVM / Practice Information

Clinic Name: ____________________

Clinic Address: ____________________

Telephone Number: (____) __________ Fax Number: (____) __________

Referring DVM: ____________________

Referring DVM Signature: ____________________

Primary Veterinary Diagnosis: ____________________

Prognosis Offered: ____________________

Current Preferred Treatment: **Chiropractic**

Treatment to Date: ____________________

Medications: ____________________

The following are enclosed:

- ☐ Radiographs
- ☐ Radiographic Report (s)
- ☐ Laboratory Results
- ☐ Advanced Imaging
- ☐ Advanced Imaging Report (s)

*** Clients MUST provide evidence of current rabies vaccination ***

Rabies vaccination date: ____________________