

LEVERING ANIMAL CHIROPRACTIC

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REQUEST FOR LEVEL OF CONSULTATION AND PARTICIPATION FROM PRIMARY VETERINARIAN

Date: _____

Primary Veterinarian _____
Clinic Name _____
Address _____
Telephone Number _____
Fax Number _____

Client Name: _____
Address: _____
Telephone No. _____
E-mail : _____

As a primary caregiver, the patient listed below has been seen, examined, and/or treated by myself or the following conditions:

Patient Name: _____

Species: _____ Breed: _____ Age: _____

At this time I deem it appropriate to refer this patient to Dr. Julie Levering (Chiropractor) for specialized secondary care. All information pertaining to this patient's condition(s) and health history, including, but not limited to, previous diagnostic tests, diagnoses, treatment, and prognoses are being forwarded to Dr. Levering by:

____ Telephone: 630-801-3389
____ Fax: 630-818-2346

I would appreciate it if you would let me know what kind of future communication you would like regarding the chiropractic care of this patient. If you have any questions regarding the chiropractic care being rendered, please feel free to call me. Thank you.

Signed by Veterinarian: _____

Date: _____

