LEVERING ANIMAL CHIROPRACTIC

Telephone: 630-801-3389 backdoctor92@sbcglobal.net
Fax: 630-818-2346 www.LeveringChiropractic.com

REQUEST FOR LEVEL OF CONSULTATION AND PARTICIPATION FROM PRIMARY VETERINARIAN

Date:

Primary Veterinarian _____ Client Name: _____
Clinic Name _____ Address: _____
Address _____ _____
Telephone Number _____ Telephone No._____
Fax Number _____ 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: _____