

Dr. Emma Schroeder McClintock, D.C.

P: 231-402-0081

F: 231-903-6421

VETERINARY REFERRAL REQUEST FOR CHIROPRACTIC CARE

Dear _____, Date of Request: _____

Your client, listed below, has requested that I provide chiropractic care for their animal, also listed below. The State of Michigan requires that I obtain a referral from the animal's veterinarian before providing this care. In order to provide the referral that your client has requested, please:

- Review and sign this form
- Indicate the level of communication and/or involvement, regarding care, that you would like to receive from me
- Return this form via email to: info.equinoxchiropractic@gmail.com or fax to 231-903-6421

I am a Certified Animal Chiropractor, after passing the IVCA (International Veterinary Chiropractic Association) certification examinations following the completion of the 210-hour certification course at Options for Animals College of Chiropractic. My IVCA certification number is 1393. I hold an active Michigan Chiropractic license. I also offer soft tissue bodywork, cold laser therapy utilizing the Erchonia Class II laser, as well as PEMF therapy for both small and large animals. If you need additional information, please feel free to contact me at my cell number, (231) 402-0081.

Animal Owner's Name: _____

Appointment Date: _____

Animal's Name: _____

Equine _____

Canine _____

Feline _____

Breed: _____

Age: _____

Gender: _____

Reason for Seeking Chiropractic Care:

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- o Please call me as soon as possible to discuss this case. I would like to be involved in decisions concerning your chiropractic care.
- o Please send me a copy of your chiropractic treatment notes for review.
- o Do not send any additional information to me, only consult me if a traditional veterinary condition or emergency arises.
- o Do not treat this patient with chiropractic care, however cold laser or PEMF therapies would be approved for the animal's current condition.
- o Do not treat this patient with chiropractic care or any therapies, as his/her condition, in my opinion, can only worsen with that type of care.

Please list any special considerations such as contraindications or other health related matters that may influence chiropractic care:

VETERINARIAN: _____
CLINIC NAME: _____
CLINIC ADDRESS: _____
CLINIC PHONE #: _____
CLINIC FAX #: _____
DVM SIGNATURE: _____
DATE: _____