Paradox Chiropractic PA

Humankind 4 Equine ♦ Canine ♦ Feline

Dr. DeAnn Adams, Doctor of Chiropractic

paradoxchiropractic@gmail.com ~ Ph: (320) 632-6757 ~ Fax: (320) 315-4291 ~ Cell: (651) 249-8446

P.O. Box 562 Little Falls, MN 56345

VETERINARY REFERRAL REQUEST FOR CHIROPRACTIC CARE

Dear Dr. _____ Date of Request: _____

Your client, listed below, has requested that I provide chiropractic care for their animal, also listed below. Minnesota law 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 regarding care that you would like to receive from me
- return this form via fax at **(320) 315-4291** or mail to **P.O. Box 562 Little Falls, MN 56345**

I am certified in Animal Chiropractic by the International Veterinary Chiropractic Association (IVCA # 0668). I hold MN Chiropractic License # 3616 and Animal Chiropractic Registration #AC 024 with the MN Board of Chiropractic Examiners. If you need additional information, please feel free to call me at (320) 632-6757. Also, check out my Web Pages at **paradoxchiropractic.com**

Animal Owner's Name: _____

Phone Number: _____ Appointment Date: _____

Animal's Name: _____ Horse ____ Dog ____ Cat ____

Breed: _____ Age: ____ Gender: _____

Reason for seeking chiropractic care: _____

_____

☐ Please send me a copy of your chiropractic treatment notes for review.

☐ Please call me as soon as possible to discuss this case. I would like to be involved in decisions concerning your chiropractic care.

☐ Do not send any additional information to me, only consult me if a traditional veterinary condition or emergency arises.

☐ Do not treat this patient with chiropractic care, 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 Name: _____

Clinic Name: _____

Clinic Address: _____

Clinic Phone: _____ **Clinic Fax:** _____

DVM Signature: _____ **Date:** _____