

Healthsource Chiropractic of St. Cloud
Dr. Melissa Loidolt, Chiropractor

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Ph: (320) 230-8920 ~ Fax: (320) 230-8922
1246 32nd Ave North, Saint Cloud, Mn 56303

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
- return this form via fax at (320) 230-8922, email to backtracktoday@gmail.com, or mail to 1246 32nd Ave. N, St Cloud, Mn 56303

I am certified in Animal Chiropractic through the state of Minnesota. I hold MN Chiropractic License #4468 and Animal Chiropractic Registration #025 with the MN Board of Chiropractic Examiners. I have passed board testing through International Veterinary Chiropractic Association. If you need additional information, please feel free to call me at (320) 230-8920.

Animal Owner's Name: _____

Phone Number: _____

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

Breed: _____ Age: ___ Gender: _____

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- 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:** _____

Vet Signature: _____ **Date:** _____