Motion Wellness Animal Chiropractic-Dr. Keith M. Billstein, D.C.

Fax # 888-392-5901 Cell# 763-213-5068
103 S Rum River Rd, Princeton, MN 55371 & 3722 7th Ave, Anoka MN 55303

VETERINARY REFERRAL REQUEST FOR CHIROPRACTIC CARE

Dear Dr. _____

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 **888-392-5901** or e-mail at: **Vetreferral@motionwellnessmn.com**

I am a Certified Animal Chiropractor, certified by the AVCA (American Veterinary Chiropractic Association), my certification number is 1095. I hold MN Chiropractic license-# 1983 and Animal Chiropractic Registration # AC 033 with the Minnesota Board of chiropractic examiners. If you need additional information, please feel free to contact me at (763) 213-5068.

Owners Name:_____
Phone Number:_____
Address:_____ Zip Code: _____
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: _____
CLINIC NAME:_____ Email address:_____
CLINIC ADDRESS:_____
CLINIC PHONE #:_____ CLINIC FAX:_____

DVM SIGNATURE:_____ DATE:_____