



**REQUEST FOR LEVEL OF CONSULTATION  
PARTICIPATION FROM PRIMARY VETERINARIAN**

TO: \_\_\_\_\_

The patient listed below has been requested to **be seen and treated with, and only with, chiropractic care**, by Dr. Zephania Cole, of Align Chiropractic & Acupuncture, PLC, for symptoms related to the following condition(s):

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE BE AWARE THAT YOUR NAME AND/OR CLINIC NAME WAS GIVEN AS THE PRIMARY HEALTH CARE PROVIDER FOR THIS PATIENT.**

Please review the following, check the appropriate boxes, complete all requests, and return the form to Dr. Zephania Cole. Thank you.

- The patient listed below is being seen in our clinic.
- The patient listed below has been examined at this clinic for the conditions listed above.
- Please call me as soon as possible to discuss this case. I would like to be involved in all decisions concerning your chiropractic care.
- Please send me a copy of your chiropractic treatment plan for review.
- Do not send any additional information to me, only consult me if a traditional veterinary condition or emergency arises, if you need to alter your chiropractic treatment plan, or at the termination of treatment.
- Please send copies of all of your chiropractic care for my files.
- Do not treat this patient with chiropractic care, as his/her condition, in my opinion, can only worsen with chiropractic 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 can be forwarded to Dr. Zephania Cole by:

Telephone: 507-235-8485

Fax: 507-238-1578

Mail: 204 Lake Avenue, Suite 203, Fairmont, MN 56031

**Veterinarian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Client Name: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Species: \_\_\_\_\_ Breed: \_\_\_\_\_ Age: \_\_\_\_\_

Signed by client \_\_\_\_\_ Date: \_\_\_\_\_