

# Veterinarian Referral Form



animalacupressuretherapy.com  
23 Betts Avenue  
Grimsby, Ontario  
L3M 2S7  
905-818-5708

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

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

Age/Date of Birth: \_\_\_\_\_

Species/Breed: \_\_\_\_\_

Sex (check one):  M  Mn  F  Fs

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## Referral for Acupressure Treatments:

Please attach relevant information on surgical or medical condition below or in a separate document.

Please Check all that apply:

- Evaluate and treat as indicated and/or
- Therapeutic Exercises
- Client Education
- Weight Management Program

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## Special Instructions, Precautions, or other Comments

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

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As the referring veterinarian, I understand that I remain the primary care provider for the above-mentioned animal.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Printed Name of DVM**

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Date: \_\_\_\_\_