Acupressure for all Creatures

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Veterinarian Referral Form

Client Name: _____

Patient Name: _____

Age/Date of Birth: _____

Species/Breed: _____

Sex (circle one): M Mn F Fs

Weight (circle one): Under | Normal | Over

Referral for Acupressure Sessions:
Please attach relevant information on surgical or medical condition below or in a separate document.

_____

Special Instructions, Precautions, or other Comments

_____

_____

_____

_____

_____

Referring veterinarian's permission to evaluate and carry out acupressure sessions:

_____ _____
Signature of Referring Veterinarian Printed Name of DVM

Date: _____

Address: _____

_____

Phone: _____ Email: _____