REFERRAL FORM

CLIENT DETAILS	
NAME:	
ADDRESS:	
TOWN:	POST CODE:
CONTACT NUMBER:	EMAIL:
PET DETAILS	
PET'S NAME:	BREED:
SEX & NEUTER STATUS:	AGE / DOB:
CLIENT DECLARATION	
☐ I confirm that the information I have provided is accurate and complete to the best of my knowledge. I understand and agree to the terms of business and consent to the sharing of relevant clinical information for the purposes of my animal's care.	
☐ I consent to photographs and/or videos of my animal being taken during appointments and understand that these may be used for educational or promotional purposes, including on social media. I understand that no identifying personal information will be shared without my explicit permission.	
CLIENT SIGNATURE:	DATE:

VETERINARY PRACTICE DETAILS	
PRACTICE NAME:	VET SURGEON:
CONTACT NUMBER:	PRACTICE EMAIL:
REASON FOR REFERRAL	
CHRONIC PAIN REFERRAL: ☐	ACUPUNCTURE REFERRAL: ☐
PAIN HISTORY:	
DIAGNOSIS:	WEIGHT (KG):
CURRENT MEDICATIONS:	
VET SIGNATURE:	DATE:
Please return a completed copy of this form to james@thepainvetwarwickshire.co.uk along with a copy of the patient's medical history.	
CHRONIC PAIN REFERRAL	For full Chronic Pain Referrals, please also send the following: • Any relevant referral reports including diagnostic imaging reports • Copies of any relevant x-ray images if available (DICOM format preferred)
ACUPUNCTURE ONLY REFERRAL:	☐ For acupuncture only service, the referring veterinary surgeon confirms there are no known medical contraindications to acupuncture in this patient.