94 Dunlop Street
Wallacetown
03 235 8825
info@k9essentials.co.nz
www.k9essentials.co.nz

Swim Therapy Vet Referral

Owner Details

Name _____

Address _____

_____

_____

Post Code _____

Email _____

Phone (0) _____

(02) _____

Dog Details

Name _____

Breed _____

Sex M / F Age _____

Colour _____

Vacinations current Y / N

Insured Y / N

Company _____

Policy # _____

THE INFORMATION BELOW IS TO BE COMPLETED BY THE TREATING VET

Veterinary Clinic _____

Vet's Name _____

Condition to be treated? cautions / comments / specific treatment requested

_____

_____

_____

_____

In your opinion, is the dog in suitable condition to undergo swim therapy? Y / N

Signed Date / / 201

TO BE COMPLETED BY THE OWNER

I have discussed swim therapy with my vet and I am not aware of any reason my dog should not undergo swim therapy. I have read and accepted K9 Essentials swim therapy terms & conditions.

Signed _____ Date / / 201