COMPANION ANIMAL LASER THERAPY
REFERRAL FORM

Central Valley Veterinary Hospital
#124-1940 Kane Road
Kelowna, BC V1V 2J9
ph: 250-762-7181
email: centralvalleyvet@shaw.ca

Patient Information:

Name:	DOB:
Breed:	Colour:
Sex:	Weight:

Client Information:

Name:
Address:
Phone #:

Diagnosis & Duration:

Any history of cancer/tumor(s): ☐ YES ☐ NO
If yes, please explain:

Laser Therapy Request:

☐ **Cervical Spine**	☐ **Thoracic Spine**	☐ **Lumbar Spine**
☐ **Hip left/right**	☐ **Patella left/right**	☐ **Shoulder left/right**
☐ **Carpal/metacarpal/phalanges left/right**		☐ **Elbow left/right**

☐ **Other:**_____ **location:**_____

Referring Veterinarian:
Name:
Clinic:
Phone #:
Email:

Please send completed referral to centralvalleyvet@shaw.ca

Thank you for your referral.

00/00/00 CVV Laser Therapy Referral Form TECHNICIANS