

**OWNERS DETAILS**

|          |  |            |  |
|----------|--|------------|--|
| Surname  |  | First Name |  |
| Address  |  |            |  |
| Postcode |  |            |  |
| Home No. |  | Mobile No. |  |
| Email    |  |            |  |

**VETERINARY DETAILS**

|               |  |  |  |
|---------------|--|--|--|
| Practice Name |  |  |  |
| Vets Name     |  |  |  |
| Address       |  |  |  |
| Postcode      |  |  |  |
| Telephone No. |  |  |  |
| Email         |  |  |  |

**DOGS DETAILS**

|                    |  |            |  |
|--------------------|--|------------|--|
| Name of Dog        |  | Sex        |  |
| Breed              |  | Colour     |  |
| D.O.B              |  | Age        |  |
| Insurance Co.      |  | Policy No. |  |
| Date of last vac.  |  | Weight     |  |
| Surgical Procedure |  |            |  |
| Date of Surgery    |  |            |  |

Summary of Dogs condition & Surgery

Current medication

Other pre-existing medical conditions

**I DECLARE THAT I AM THE LEGAL OWNER OF THE ABOVE NAMED DOG AND THAT THE INFORMATION PROVIDED IN THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO DECLARE THAT I ACCEPT MY VETS OPINION AND WANT ADAMS CANINE HYDROTHERAPY TO PROCEED WITH TREATMENT.**

|            |  |      |  |
|------------|--|------|--|
| Print Name |  | Date |  |
| Signature  |  |      |  |

**THIS SECTION CAN ONLY BE SIGNED BY A VETERINARY SURGEON**

**IN MY MEDICAL OPINION THE ABOVE NAMED DOG CAN PROCEED WITH THE FOLLOWING TREATMENT**

|              |     |    |               |     |    |
|--------------|-----|----|---------------|-----|----|
| HYDROTHERAPY | YES | NO | PHYSIOTHERAPY | YES | NO |
|--------------|-----|----|---------------|-----|----|

|            |  |      |  |
|------------|--|------|--|
| Print Name |  | Date |  |
| Title      |  |      |  |
| Signature  |  |      |  |