Essex Equine & Canine
LASER THERAPY

Alexandra Thake CERT HSA,IRCH,MIRVAP,MBMLA

Equine & Canine K.Laser & INDIBA Practitioner.

Veterinary Referral/Consent Form

OWNER'S DETAILS

NAME: _____

ADDRESS: _____

TEL: _____

ANIMAL'S DETAILS

NAME: _____

BREED: _____AGE: _____

WE REQUIRE VETERINARY PERMISSION AND (WHEN NECESSARY) MEDICAL HISTORY FOR EVERY ANIMAL THAT UNDERGOES CLASS 4 &/OR INDIBA-RADIO FREQUENCY THERAPIES .

VETERINARY SURGEON & PRACTICE DETAILS

NAME: _____

ADDRESS: _____

TEL: _____

SUMMARY OF THE ANIMALS INJURIES OR CONDITION, AREAS OF CAUTION, SURGERY DATE, COMMENTS TO BE TAKEN INTO ACCOUNT ETC.

DETAILS OF CURRENT MEDICATION: _____

_____

In my opinion, the above named animal is in a suitable state of health and I give my consent for the above named animal to undergo the below treatment(s);

(Please Tick The Box Of The Specified Treatment)

K-Laser Class IV ☐

INDIBA- 448KHz Radio Frequency ☐

Veterinary Signature: _____**DATE:** _____

INDIBA®

K-LASER®