Love 4 Paws

Elana Titus, BA Hons, RMT, CVMRT
Certified Veterinary Massage and Rehabilitation Therapy Services

MEDICAL INFORMATION / CONSENT FORM

Owner's name:	
Address:	Postal Code:
Phone:	Cell:
Dog/Cat's name:	
Sex: M MN F FS	Date of birth:
Breed:	Colour:

Rehabilitation/physical therapy program (applies to injured, post-surgical, arthritic, musculoskeletal, and neurological cases).* **Note**: Assessment prior to treatment design and implementation will be provided by Elana Titus.

Please provide diagnosis and pertinent medical history of condition afflicting the above mentioned patient:

Surgical and/or other procedures performed and date(s):

Medication(s)/Supplements:

Any concerns or contraindications to Massage, Rehabilitation, or Shockwave Therapy to the above mentioned patient? (Heart Murmur, Epileptic, Diabetic, Coagulation issues, etc.)

Veterinarian's name (print):_____

Veterinarian's signature:_____

Best way to contact you? _____

Clinic: _____Date:_____

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