OKLAHOMA K9 PT
CANINE REHAB & WELLNESS

Massage Therapy Referral Form

Veterinary clinic: _____ Phone Number: _____

Client: _____ Pet: _____

Precautions/Contraindications:

_____

_____

Other medical conditions/medications:

_____

_____

Any other pertinent information you would like to disclose:

_____

_____

*This referral is for massage therapy services ONLY. All rehabilitation services will require a separate referral form. Please feel free to reach out with any questions at Oklahomak9pt@gmail.com or (918) 856-6018. Our Fax is (918) 600-1948 Thank you for your time.

☐ The dog listed above is fit to receive Canine Massage Therapy.

_____ _____

DVM Signature Date