**Owner Details**

|  |
| --- |
| **Name:** |
| **Address:** |
|  | **Postcode:** |
| **Telephone / Email:** |

**Animal Details**

|  |  |  |
| --- | --- | --- |
| **Name:** | **DOB / Age:** | **Gender:** |
| **Breed:** | **Colour:** | **Working Discipline:** |
| **Insured Y / N****Insurance Company:** | **Wormed Y / N** | **Vaccinations Y / N** |

**Veterinarian Details**

|  |
| --- |
| **Name of Veterinary Surgeon:** |
| **Practice Address:** |
|  | **Postcode:** |
| **Telephone / Email:** |
| **Comments e.g. summary of animal’s condition/current problem, pre-existing conditions/injuries, behavioural issues, current medications, previous investigations/findings/treatments, special patient requirements:**  |

I confirm that the above-named horse/dog is a patient under my care and give my consent for the above-named horse/dog to receive massage therapy / myofascial release / soft tissue treatments from HAC Therapies.

**Signature: Date:**

**Name of veterinary surgeon (printed):**

**Stamp of veterinary practice (where applicable):**

I declare that I am the legal owner of the above-named horse/dog and that all information provided is correct. I give my consent for the above-named horse/dog to receive massage therapy / myofascial release / soft tissue treatments.

**Signature: Date:**

**Name of owner (printed):**