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MOBILE VETERINARY CARE CONSENT FORM

Patient Name:

Age:

Sex:

Species:

Breed:

Client Name:

Address:

Tel:

Summary of Clinical Problem:

Vet Name:

Practice Name:

Practice Address:

I consent to the above animal receiving primary veterinary care at home via Chapel Fell Vets for the above-named condition. I understand that my practice remains responsible for any routine, emergency or out of hours treatment for this patient in line with the RCVS Under Care Guidelines. In the event at home treatment is not in the best interest of the patient the client will be advised to return to your practice for ongoing care.

Signed

Date:

Printed

Once completed please return this form, alongside the patient's clinical history via email to emma@chapelfellvets.com

Thank you for this referral. A full clinical report will be returned to you after treatment.