Cara Veterinary Group

Supporting Responsible Pet Ownership

Laser Therapy & Cryotherapy Referral Form

Cara Veterinary Hospital | 01 8853253

REFERRING PRACTICE

Practice Name: _____ Referring Vet: _____

Phone: _____ Email: _____

Preferred correspondence: ☐ Email ☐ Phone ☐ Written report

CLIENT & PATIENT DETAILS

Owner: _____ Phone: _____

Email: _____

Patient: _____ Species: _____

Breed: _____ Weight: _____

Age/DOB: _____ Sex: ☐ M ☐ F Neutered: ☐ Y ☐ N

REFERRAL TYPE

☐ Laser Therapy ☐ Cryotherapy ☐ Both

CLINICAL SUMMARY

Presenting Complaint / Diagnosis:

_____

_____

Duration: _____

Current Medications: _____

Previous Treatments / Surgery: _____

Diagnostics: ☐ Radiographs ☐ Bloods ☐ FNA/Biopsy ☐ Other

TREATMENT AREA

Anatomical Location: _____

Side: ☐ Left ☐ Right ☐ Bilateral ☐ Midline

If Cryotherapy – Lesion size/type: _____

Photos attached: ☐ Yes ☐ No

MEDICAL CONSIDERATIONS

☐ Neoplasia ☐ Pregnancy ☐ Epilepsy ☐ Clotting disorder

☐ Immune-mediated disease ☐ Sedation concerns ☐ Other

Additional Notes:

_____

REFERRAL AIM

☐ Pain management ☐ Mobility improvement ☐ Inflammation reduction

☐ Post-op support ☐ Lesion removal ☐ Palliative care ☐ Other

CASE MANAGEMENT

☐ Return to referring practice ☐ Shared care ☐ Full case transfer

DECLARATION

I confirm the owner has consented to referral and sharing of relevant clinical information.

Signature: _____ Date: _____