



APBC

ASSOCIATION OF PET  
BEHAVIOUR COUNSELLORS

# REFERRAL FORM

## For Behaviour Consultation

Behaviour problems may arise both directly and indirectly as a result of concurrent or previous medical conditions. Veterinary involvement is therefore essential to diagnose any causes of, or contribution to the problem that will require veterinary treatment. This may be prior to or alongside behaviour modification for any given case. In order to safeguard the welfare of your patient and indicate your approval for referral, please complete the following form:

### VETERINARY SURGEON DETAILS

REFERRING VETERINARIAN

PRACTICE NAME AND ADDRESS

POSTCODE

TELEPHONE

EMAIL

### CLIENT DETAILS

OWNER'S NAME

PATIENT'S NAME/ AGE/ SPECIES AND BREED

GENDER/ NEUTERED STATUS AND DATE OF NEUTERING

PASSPORT/MICROCHIP NO. (IF RELEVANT)

DATE OF LAST HEALTH CHECK

PRESENTING PROBLEM

I HEREBY ACKNOWLEDGE MY APPROVAL FOR THE CLIENT DESCRIBED ABOVE TO BE REFERRED FOR MANAGEMENT, TRAINING AND/OR BEHAVIOURAL THERAPY REGARDING THE CURRENT PROBLEM TO:

APBC MEMBER CONTACT DETAILS

WEBSITE

TELEPHONE

EMAIL

THE ABOVE MAY NEED TO DISCUSS SIGNS OF SPECIFIC MEDICAL CONDITIONS WITH YOU, THE REFERRING VETERINARIAN, DURING THE COURSE OF THEIR WORK. THIS IS AT NO TIME TO BE TAKEN AS AN ATTEMPT TO DIAGNOSE ANY MEDICAL CONDITION UNLESS THE MEMBER IS THEMSELVES A QUALIFIED VETERINARIAN WHO EXPLICITLY STATES A DIAGNOSIS.

PLEASE TICK APPROPRIATE BOX:

MEDICAL HISTORY ACCOMPANIES THIS FORM

MEDICAL HISTORY SUPPLIED BY

POST

PHONE

EMAIL

SIGNED \_\_\_\_\_ MRCVS      DATE: \_\_\_\_\_

I, \_\_\_\_\_, THE OWNER/PERSON WITH FULL LEGAL RESPONSIBILITY\* OF THE ABOVE NAMED ANIMAL, CONSENT TO THE DISCLOSURE OF CLINICAL INFORMATION REGARDING THIS ANIMAL BY MY VETERINARY SURGEON FOR THE PURPOSES OF BEHAVIOUR THERAPY. I HEREBY AUTHORISE MY VETERINARIAN AND BEHAVIOURIST TO DISCLOSE DETAILS ABOUT AND DISCUSS THIS CASE. \* PLEASE STATE CAPACITY \_\_\_\_\_

SIGNED: \_\_\_\_\_      DATE: \_\_\_\_\_