



Wishing Wellness LLC

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General Veterinary Referral for Animal Massage Therapy Services

1. Animal Information

Animal's Name: _____

Species: Canine Feline Equine Other: _____

Breed: _____

Age: _____ Sex: _____ Weight: _____

Owner / Caregiver Name: _____

Phone: _____

Email: _____

2. Referring Veterinarian Information

Veterinary Practice Name: _____

Veterinarian's Name: _____

Phone: _____

Email: _____

3. Medical History & Current Condition

Primary Diagnosis (if applicable): _____

Secondary Diagnoses (if applicable): _____

Date of Most Recent Examination: _____

Current Medications: _____

Recent Surgery or Injury (include dates): _____

Medical Restrictions, Contraindications, or Areas to Avoid: _____

4. Purpose of Referral

General relaxation and stress reduction

Muscle tension relief

Geriatric support

Performance support

Post-surgical support

Lymphatic support

Mobility enhancement

Comfort care

Other: _____

Specific therapeutic considerations or goals: _____

5. Approved Modalities

Relaxation Massage

Therapeutic Massage

Myofascial Release

- Passive Range of Motion
- Lymphatic Drainage Massage
- Reflexology
- Acupressure
- Cupping (manual vacuum massage tools; non-invasive soft tissue application)
- Red Light Therapy (LED photobiomodulation; non-laser light therapy - NOT cold laser or Class III/IV laser therapy)
- Other: _____

Restrictions or limitations: _____

6. Wishing Wellness LLC Statement

Massage therapy and related complementary wellness services provided by Wishing Wellness LLC are not intended to diagnose, treat, cure, or prescribe for any medical condition. All services are performed within scope of practice and in collaboration with the referring veterinarian.

7. Veterinarian Authorization

I certify that the above animal is under my veterinary care and, to the best of my knowledge, is medically stable to receive the complementary wellness services indicated above. I understand that red light therapy provided by Wishing Wellness LLC utilizes non-laser LED light and is not cold laser or Class III/IV laser therapy. This referral provides ongoing authorization for the services selected unless otherwise revoked or modified in writing.

Veterinarian Signature: _____

Printed Name: _____

Date: _____