Arrowhead Canine Reproduction

2920 Dabney Bottom Rd
Cleveland TX 77328
936-525-9462

Veterinarian Authorization/Referral Form

To ensure compliance with the Texas Veterinary Licensing Act, it is essential to note that the licensed veterinary technician associated with Arrowhead Canine LLC will not perform surgical procedures, prescribe medications, or provide diagnoses or prognoses. Furthermore, no services that require immediate or direct supervision by a licensed veterinarian will be rendered. All services provided will require the completion of an authorization/referral form and must be conducted under the general supervision of the requesting veterinarian.

I am requesting your authorization for Michelle Clark, LVT, to perform semen cryopreservation for the following canine:

Canine's Name: _____ DOB: _____

Canine's Breed: _____

Arrowhead Canine is not a veterinary medical practice and does not employ a licensed veterinarian. Arrowhead Canine cannot diagnose or prognose, prescribe treatment or medications, or perform medical procedures or treatments. Arrowhead Canine reserves the right to cease all services and refer a client to alternative reproductive or veterinary medical facilities.
****Arrowhead Canine cannot interpret test results unless directed by the referring veterinarian.**

I authorize Michelle Clark, LVT, to perform semen cryopreservation for the canine listed above, by my signature below, and further certify that I am the owner/handler/caretaker of the above canine.

Client Name: _____ Phone: _____

Client Signature: _____ Date: _____

VETERINARIAN: Please Complete and Email

My name and signature below, as a Doctor of Veterinary Medicine, in compliance with Sec. 801.363. DELEGATION AND SUPERVISION OF ANIMAL CARE TASKS indicates I have established a valid veterinarian/client/patient(s) relationship; examined the animal to determine that semen cryopreservation will not likely be harmful; and obtained as part of the patient's permanent record a signed acknowledgement by the owner or other caretaker (above) of the patient. **Therefore, by my signature below, I authorize Michelle Clark, LVT, to perform semen cryopreservation for the animals listed above.**

Clinic: _____

Address: _____

City: _____ State: _____Zip: _____

Email: _____

Telephone: _____ Date: _____

DVM Name: _____, DVM

DVM Signature: _____

Following the completion of services, reports will be emailed to the referring veterinarian at the end of the business day.

Please email this form to arrowheadcaninerepro@gmail.com.