

**Artuvetrin® Therapy order form****Practice Account number**

ExactAccountRef01

**Order reference**

51306

**Veterinary Surgeon's name**

Practice User 01

**Veterinary Surgeon's e-mail**

practice1@test.com

**Practice phone number**

987654321

**Practice Name**

practice1

**Address\_1**

Address 1

**Address\_2**

Address 2

**Address\_3**

Address 3

**Address\_4**

Address 4

**Town**

Town - City

**Postal Code**

12345

**Country**

**Order Sent to Account Ref**

ExactAccountRef01

**Order is to be sent to**

**Invoice to be sent to**

The clinic address above

**Pet and pet owner details**

**Pet Owner’s last name**

Pet Owner First Name 02 Pet Owner Last Name 02

**Animal Name**

Pet Owner First Name 02

**Species**

Cat

**Is this order for an initial or maintenance treatment?**

Initial treatment = the first immunotherapy treatment for the patient

**Choose allergens**

**Allergen Groups English**

- English Allergen Name (Default)

**Total Allergens**

1

**Practice Comments**