

DROP OFF FORM

Client Name: _____ Patient # (Office use only) : _____
Pet Name: _____ Today's Weight: _____
Number where you can be reached today: (____) _____
Alternate Number: (____) _____

Please check all symptoms that apply to your pet:

Straining to urinate: _____ Panting: _____ Odor: _____ Frequent urination: _____ Vomiting: _____
Difficulty breathing: _____ Constipation: _____ Coughing: _____
Hair loss: _____ Diarrhea: _____ Watery Eyes: _____ Restlessness: _____
Decrease in water intake: _____ Lethargic: _____ Scooting: _____
Increase in water intake: _____ Depressed: _____ Gagging: _____
Decrease in appetite: _____ Weakness: _____ Seizures: _____
Increase in appetite: _____ Limping: _____ Shaking head: _____
Discharge: _____ Where? _____ Color? _____ For how long? _____
Pain: _____ Where? _____ Color? _____ For how long? _____
Growths: _____ Where? _____ When did you notice them? _____
Behavioral Changes: _____ Since when? _____
What are they? _____

If you have noticed diarrhea, how often are you noticing it? Since what date? Color and consistency?

If you have noticed vomiting, how often are you noticing it? Since what date? Color and consistency?

When did your pet last eat well? _____

When did your pet last drink well? _____

What does your pet's diet usually consist of? (Please be specific and include any treats, table scraps, ect.)

What brand of food are you feeding? _____

Canned or dry? _____

How often are you feeding your pet? _____ What amount? _____

We have arranged for you to leave your pet here, to allow the Veterinarian to examine your pet as soon as possible. The Veterinarian will preform a thorough physical exam as soon as the schedule allows. For the benefit of your pet's health, it is important to start treatment as soon as possible. If recommended, which procedures do you authorize?

Bloodwork: _____ Fluid Therapy: _____

Radiographs: _____ Sedation: _____

Urinalysis: _____ Medication: _____

Cytologic evaluation (lumps, bumps, ears): _____

Other diagnostics and/or treatments: _____

Please initial here if you would like to be contacted prior to any treatments or diagnostics: _____

I am the owner/agent for this pet, and I authorize and request an exam for my pet. I understand that payment is due when my pet is discharged. I accept financial responsibility for the charges incurred for this pet. I understand that I will be charged for flea medication if evidence of fleas is found on my pet.

Signature: _____ **Date:** _____