

DROP OFF FORM

Owner's name _____ Date _____

Pet's name _____ Dog _____ Cat _____ Breed _____ Age _____ Sex _____

Phone number where you can be reached at today _____ Best time to call _____

Emergency/Alternate contact if you are unavailable (Name) _____ (Number) _____

Pet's current medications and diet _____

Allergies to vaccinations or medications _____

Please choose one of the following:

_____ My pet is not having any health problems at this time and is here for routine services or vaccinations.

_____ My pet is here for a recheck.

_____ My pet is sick or is having medical problems.

If sick, please complete the following:

My main concern is _____

Length of illness or changes in pre-existing conditions _____

Eating habits are: Normal *or have* Stopped Decreased Increased

Drinking habits are: Normal *or have* Stopped Decreased Increased

Please check any symptoms or problems that you have noticed about your pet.

- | | | |
|---|---|--|
| <input type="checkbox"/> Behavior Changes | <input type="checkbox"/> Discharge (explain: _____) | <input type="checkbox"/> Shaking Head |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Gagging | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Limping | <input type="checkbox"/> Urination Decreased |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Urination Increased |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Scooting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scratching | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Other _____ | | |
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To promote the diagnosis of your pet, please authorize or decline the following:

Yes No Authorization for bloodwork if needed.

Yes No Authorization for x-rays if needed.

Yes No Authorization for sedation if needed.

Please initial treatment preference _____ Please treat my pet as needed.

_____ Please call prior to any treatment.

I certify that I am the owner (or duly authorized agent for the owner) of the above animal and I hereby give my consent to perform the services as indicated above. I am aware that all animals admitted to the hospital need to be current on their vaccinations and free from all external parasites. I assume full financial responsibility for this pet.

Signature of owner/agent

Drop-offs are scheduled for discharge after 4:00p.m. If you need an earlier pick-up time please specify: _____

Have medications been given today? _____ If so, please list: _____