



Drop Off Treatment Form

Date: _____

Client Name: _____

Pet Name: _____

What will we be seeing your pet for today?

Primary Complaints:

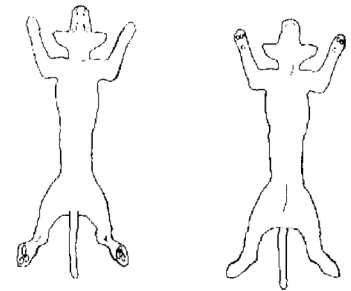
- Vomiting Blood in urine Itching Painful Diarrhea Coughing Hairloss
- Growth/Lump Blood in stool Sneezing Lethargic Ears Inappropriate Urination
- Difficulty Breathing Anorexia Eyes Difficulty Urinating Lameness/Limping
- Increased thirst Other: _____

Left (Back) Right Right (Belly)Left

If your pet has any unusual; lumps, bumps, wounds or skin irritation which you would like the doctor to address today, please note the location of each on the diagram. _____

Has your pet had an increase or decrease in any of the following: (Please circle one)

Drinking	Increased	Decreased	No Change
Appetite	Increased	Decreased	No Change
Urination	Increased	Decreased	No Change
Defecation	Increased	Decreased	No Change
Weight	Increased	Decreased	No Change



Was your pet fed today? Yes No Time of meal? _____

Is your pet current on vaccinations? _____ Date given? _____

Any previous illness/surgery? _____

Is your pet on any medications/flea control? (list) _____

What is your pet's diet? _____ Has

your pet been seen by another veterinarian for treatment? _____

May we call for records? Yes No If yes, name of clinic? _____ Any

other issues you would like addressed? _____

Please read and initial ONE of the following:

- _____ I authorize testing and treatment per estimate given and place no limit on additional charges/services deemed necessary by the veterinarian.
- _____ I authorize testing and treatment per estimate given and approve charges up to an additional \$_____.
- _____ Please call me with an estimate before performing any procedures not outlined on the estimate given. If I cannot be reached, I authorize additional treatments deemed necessary by the veterinarian.
- _____ Please call me with a revised estimate before performing any additional procedures not outlined on the estimate given. I understand that if I cannot be reached, my pet will receive NO treatments, except in the case of an emergency, other than those outlined on the original estimate.

Please read and initial ONE of the following:

We are capable of performing CPR at our facility but the chances of recovering from a full cardiorespiratory arrest episode for a significant period of time are less than 10%. The injuries and/or illnesses that accompany this situation also contributes to the poor prognosis. **The cost of performing CPR is \$383.**

- _____ I authorize resuscitation (CPR)
- _____ I do not authorize resuscitation (DNR)

Please read and initial the following:

_____ I hereby give my consent to Animal Emergency and Pet Care Clinic to perform an exam and treatment(s).

Signature of Owner/Agent _____ Date _____

Primary Phone No. Today _____ Name of Contact _____

Alternate Phone No. 1) _____ 2) _____