Pet Drop Off Treatment Form

Patient: _____ Owner: _____ Date:_____

What is the reason we are seeing your pet today? _____

Primary Complaints: Check any that apply and describe below:

Vomiting		Diarrhea		Eyes		Lethargic		Coughing	
Blood in stool		Constipation		Ears		Lameness/Limping		Sneezing	
Blood in urine		Growth/Lump		Itching		Painful		Difficulty Breathing	

Details on above conditions and indicate on diagram if painful, lumps or growths: _____

_____

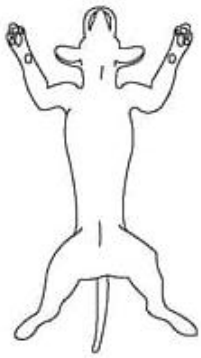
_____

_____

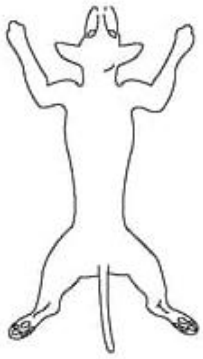
Has your pet had an increase/decrease/no change in the following:
(Please circle one)

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

Belly side up



Back side up



Did your pet eat today? If yes, please list what and the time he/she ate:_____

Has your pet been seen by another veterinarian recently? If yes, describe _____

_____

Please read and initial one of the following:

_____ Please do exam, $89 (exam + hospital ward) only and call with estimate.

OR

_____ Please perform diagnostics/procedures up to $300 until I can be contacted.

Please contact me at _____ after my pet's examination.

Signature of pet owner _____ Date _____