

Drop Off Exam / Vaccines

Client Name:

Date:

Patient Name:

Check in Technician: _____

We have arranged for you to leave your pet in our care for the day so we can perform a healthy pet examination and update their annual lab work and vaccines. This service is only for well pets! If your pet has been ill in the last 14 days they will not be eligible to be dropped off and you will be required to be present if you want them to be seen by a doctor. Please read through the following questions and answer any that may apply to your pet. Please read and sign the authorization at the end this form.

What is the purpose of your pet's visit today? _____

Has your pet experienced any of the following in the last 14 days:

<input type="checkbox"/> Vomiting	<input type="checkbox"/> Itching	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Inappropriate Urination	<input type="checkbox"/> Bloody Stool
<input type="checkbox"/> Decreased Appetite	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Coughing	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Increased Appetite	<input type="checkbox"/> Paw Chewing	<input type="checkbox"/> Trouble Breathing	<input type="checkbox"/> Straining to Urinate	<input type="checkbox"/> Limping
<input type="checkbox"/> Decreased Thirst	<input type="checkbox"/> Shaking Head	<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Urinating more	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Increased Thirst	<input type="checkbox"/> Lumps/Bumps	<input type="checkbox"/> Eye Discharge	<input type="checkbox"/> Straining to Defecate	<input type="checkbox"/> Weight Gain

Other concerns _____

What is your pet's current diet? _____

Amount fed and frequency fed per day _____

Any/All treats, snacks, cookies given to your pet _____

Was your pet fed today? Yes___ No___ Time of meal? _____

Is your pet on any medications or supplements? Yes___ No___

Medications (include supplements, how much given, and how often the medication is given): _____

Is your pet currently on heart worm prevention? Yes___ No___ Brand _____ Date given _____

Is your pet currently on flea/tick prevention? Yes___ No___ Brand _____ Date given _____

CHECK ALL VACCINES/ DIAGNOSTICS YOU WOULD LIKE YOUR PET TO RECEIVE TODAY

FOR CANINES:

<input type="checkbox"/> Rabies	<input type="checkbox"/> Annual Wellness Bloodwork
<input type="checkbox"/> Distemper	<input type="checkbox"/> Heartworm Test
<input type="checkbox"/> Leptospirosis	<input type="checkbox"/> Fecal
<input type="checkbox"/> Bordatella	<input type="checkbox"/> Nail Trim
<input type="checkbox"/> Flu	<input type="checkbox"/> Anal Glands
<input type="checkbox"/> Lyme	<input type="checkbox"/> Other: _____

FOR FELINES:

<input type="checkbox"/> Rabies 1 Year	<input type="checkbox"/> Annual Wellness Bloodwork
<input type="checkbox"/> Rabies 3 Year	<input type="checkbox"/> FeLv/FIV Testing
<input type="checkbox"/> Distemper	<input type="checkbox"/> Nail Trim
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Other: _____

I understand payment is due in full when my pet is discharged. However, a deposit may be required after an estimate is prepared and discussed. I accept financial responsibility for charges incurred for this pet. I understand that I will be charged for flea medication and a dose will be applied if evidence of fleas is found on my pet today.

Signature: _____ Date: _____ Phone Number: _____