

Drop Off Form

The information requested on this form will tell us the things you want us to do for your animal's visit. It is the only way we can be certain that we understand what you want. Therefore, it is very important for you to be as specific as possible. If we need additional information, we can reach you at the number you give us today. Thank you.

Owner's Name _____ Date _____

Is address & phone number on medical record still correct? Yes () No ()

Phone number where you can be reached today _____

Is your pet sick? Yes () No () Major Complaint? _____ When?

Has pet been treated for same condition recently? Yes () No ()

How long has condition been going on? _____

Current diet _____ No. feedings per day ____

Last time <animal> ate _____ Approximate amount (cups) _____

History

**Vaccinations needed: All needed () Rabies () Distemper Series () Other (): _____
Decline ()**

Any injury or accident in the past 30 days? Yes () No ()

If yes, what? _____

Had any surgery in the past 30 days? Yes () No ()

If yes, what? _____

Allergic to any medications? Yes () No ()

If yes, what? _____

Dog on Heartworm Preventive? Yes () No ()

Currently on any medications? Yes () No ()

If yes, what? _____

Appetite normal? Yes () No () If no, how long? _____ Vomiting? Yes () No () If yes, how long? _____

Diarrhea? Yes () No () If yes, how long? _____ Listless? Yes () No () If yes, how long? _____

Drinking more or less water than usual? Yes () No ()

If yes, please explain: _____

Weakness? Yes () No () If yes, how long? _____ Coughing? Yes () No () If yes, how long? _____

Sneezing? Yes () No () If yes, how long? _____

Gagging? Yes () No () If yes, how long? _____

Urinating more or less than usual? Yes () No ()

If yes, Please explain? _____

Scratching? Yes () No () If yes, how long? _____

Shaking head? Yes () No () If yes, how long? _____

Limping? Yes () No () Which leg? LF RF LR RR How long? _____

Scotting? Yes () No () If yes, how long? _____

History of seizures? Yes () No () How long? _____ Unusual lumps or bumps? Yes () No ()

Bad breathe? Yes () No () How long? _____ Weight Loss or gain? Yes () No ()

Unusual discharge? Yes () No () Where? _____ Behavioral changes? Yes () No () What? _____

Anything else we need to know? _____

Call the office by 11:00 a.m. (morning procedures) or 3:00 p.m. (afternoon procedures) to check on progress and in case we have not been able to get in touch with you.

Continued...

OWNER RELEASE: The clinic and staff will **NOT** be held liable for any problems that develop provided reasonable care and precautions are followed. I understand that ANY problem that develops with <animal> while I'm absent will be treated as deemed best by the staff veterinarians and I assume full responsibility for the treatment expense involved.

OWNER/AGENT _____

DATE _____

VACCINATION DECLINE

“I understand that state law requires rabies vaccination for all pets. I also understand clinic policy requires Distemper / Parvo vaccination for dogs and / or Feline Distemper vaccine for cats be current or has been shown to have protective immunity against these diseases. I decline vaccination at this time because vaccinations have been given elsewhere and are current. If my pet bites another animal or person while at this veterinary clinic, I will provide written evidence of a current rabies vaccination within 24 hours of notification to do so.”

Owner/Agent Initial _____ Date _____