Drop off Treatment Form

Patient: Owner: Date:

Breed: Sex: Age: Weight _____

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: _____

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

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 and place no limit on additional charges/services deemed necessary by the veterinarian.

_____ 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 and/or diagnostics deemed necessary by the veterinarian.

_____ Please call me with an estimate before performing any additional procedures. I understand that if I cannot be reached, my pet will receive NO treatments, except in the case of an emergency.

Please read and initial the following:

_____ I hereby give my consent to Delaporte Veterinary Hospital to perform an physical exam and any approved diagnostics or treatments.

_____ In the event my pet has to stay overnight, I understand that they will not be monitored during the overnight hours and I have the option to take them to the VEC for overnight care

****If complications should develop and my pet stops breathing and/or heart stops while in hospital; I elect the following and assume financial responsibility for my choice: *(initial one below)*

CPR_____(Cardiopulmonary Resuscitation) **DNR**_____(Do Not Resuscitate)

Owner/Agent Name: _____

Signature of Owner/Agent_____

Date_____

Primary Phone No. Today_____

Emergency Contact: _____ Phone: _____

In the event I cannot be reached, I authorize the above emergency contact to make medical decisions for my pet and understand I will be financially responsible for any fees incurred as a result of those decisions. _____ (initial)