Drop Off Admission

CLINIC USE ONLY

Account #: _____ **Staff:** _____

Date: _____

Carrier/Leash Left: Yes / No

Owner Name: _____ Pet Name: _____

Best Contact Phone #: _____ Best method of contact: Phone Call / Text

Reason for visit today: _____

Current Medications (please include when last dose was given):

_____

Current Diet: _____ Amount fed per day: _____

Current Appetite: ☐ normal ☐ increased ☐ decreased

Water Consumption: ☐ normal ☐ increased ☐ decreased

Recent Medical History

(Please Circle Yes or No & Describe)

Recent injury, accident, or surgery? Yes / No _____

Allergic to any medications? Yes / No _____

Vomiting? Yes / No How often? _____

Diarrhea? Yes / No Consistency? _____

Urinating more or less than usual? Yes / No

_____

Limping? Yes / No Which leg & for how long? _____

Coughing, Sneezing, or Gagging? Yes/ No How long? _____

Skin Problems? Yes / No _____

Any lumps or bumps on pets body? Yes / No Location: _____

Weight Loss or Gain? Yes / No _____

Any behavioral changes? Yes / No _____

Heartworm Preventative? Yes / No What kind? _____

Flea / Tick Preventative? Yes / No What kind? _____

Anything else we should know?

_____

I authorize the following diagnostic tests:

☐ Bloodwork ☐ X rays ☐ Needle biopsy/ cytology ☐ Urinalysis/ Cytology

* After the doctor has examined your pet, we will be happy to make a treatment plan for you before procedures are performed.

Your pet will be seen on a priority basis. This will be based on the nature of the problem and the time your pet was dropped off with us today.

Signature: _____ Date: _____