Drop Off Treatment Form

Patient _____ Owner _____ Date _____ Breed _____ Sex M MC F FS
Age _____

What will we be seeing your pet for today? _____

_____

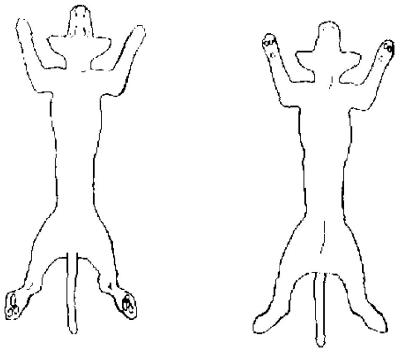
Primary Complaints:

___ Vomiting	___ Blood in urine	___ Itching	___ Painful	___ Diarrhea	___ Coughing
___ Growth/Lump	___ Blood in stool	___ Sneezing	___ Lethargic	___ Ears	___ Inappropriate Urination
___ Difficulty Breathing	___ Anorexia	___ Eyes	___ Difficulty Urinating		___ Lameness/Limping
___ Increased thirst	___ Hair loss	___Other: _____			

If your pet has any unusual; lumps, bumps, wounds or skin irritation which you would like the doctor to address today, please note the location of each on the diagram.

_____

_____



Has your pet had an increase or decrease in any of 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

Is your pet current on vaccinations?_____ Date give? _____
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 per estimate given and place no limit on additional charges/services deemed necessary by the veterinarian.

_____ I authorize testing and treatment per estimate given and approve charges up to an additional $_____.

_____ 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 deemed necessary by the veterinarian.

_____ Please call me with a revised estimate before performing any additional procedures not outlined on the estimate given. I understand that if I cannot be reached, my pet will receive NO treatments, except in the case of an emergency, other than those outlined on the original estimate.

Please read and initial the following:

_____ I hereby give my consent to Vine Grove Veterinary Hospital to perform an exam and treatment(s).

Signature of Owner/Agent_____ Date_____

Printed Name of Owner/Agent_____ Contact Number_____