Drop Off Treatment Form

Account (Hospital Use): _____ Date: _____
Patient Name: _____ Owner Name: _____
Breed: _____ Sex M MC F FS Age: _____

What will we be seeing your pet for today?

_____

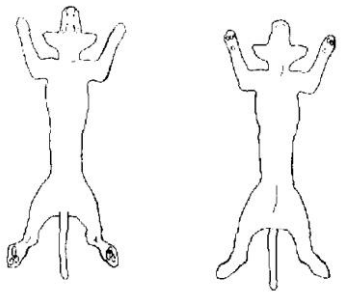
Primary Complaints:

____ Vomiting ____ Blood in urine ____ Itching ____ Painful ____ Diarrhea ____ Coughing ____ Hairloss
____ Growth/Lump ____ Blood in stool ____ Sneezing ____ Lethargic ____ Ears ____ Inappropriate Urination
____ Difficulty Breathing ____ Anorexia ____ Eyes ____ Difficulty Urinating ____ Lameness/Limping
____ Increased thirst ____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. _____

_____

Left (Back) Right Right (Belly)Left



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

Was your pet fed today? ____ Yes ____ No Time of meal?
_____

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 ONE of the following:

We are capable of performing CPR at our facility but the chances of recovering from a full cardiorespiratoy arrest episode for a significant period of time are less than 10%. The injuries and/or illnesses that accompany this situation also contributes to the poor prognosis. **The cost of performing CPR is $268.**

_____ I authorize resuscitation (CPR)

_____ I do not authorize resuscitation (DNR)

Please read and initial the following:

_____ I hereby give my consent to Animal Emergency and Pet Care Clinic to perform an exam and treatment(s).

Signature of Owner/Agent_____ Date_____
Primary Phone No. Today_____ Name of Contact_____
Alternate Phone No. 1)_____ 2) _____

1614 NC Hwy 105
Boone, NC 28607
(828) 268-1159
(828) 266-7222 (Fax)