DROP OFF FORM

Owner's Name: ______________________________ Pet's Name: _____________________

Phone number(s) where you can be reached today? ____

Reason for drop off: ____

____

What food does your pet currently eat? ____

Is your pet exhibiting any of the following symptoms?

( ) Vomiting	( ) Weight loss	( ) Frequent urination
( ) Diarrhea	( ) Hair loss	( ) Blood in urine
( ) Coughing/Gagging	( ) Itching	( ) Lameness
( ) Weakness	( ) Sneezing	( ) Difficulty urinating
( ) Increased thirst	( ) Eye discharge/redness	( ) Odor/discharge from ears

( ) Other concerns:

____

____

Please describe in detail (i.e. duration, frequency)

____

____

I, the owner of ______________________, hereby give permission to perform the following tests:

( ) Blood work / Urinalysis / Fecal

( ) X –rays

( ) Sedation if necessary

( ) Other tests as the Doctor deems necessary

- *Any animal with fleas or flea dirt will be treated at the owner's expense*
- *All animals' vaccinations must be current before admission to the clinic unless waived by one of the veterinarians for medical reasons.*

Date: ________________ Signature of Owner or Agent: __________________________________