Drop Off Treatment/History Form

UNION ANIMAL HOSPITAL

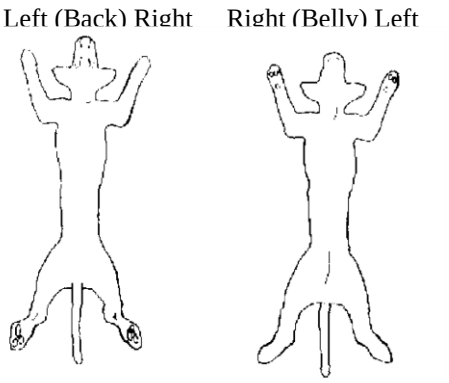
Patient_____ Owner_____ Date _____
Cat Dog Other:_____ Breed _____ Sex M MC F FS Age _____

What will we be seeing your pet for today?_____

Primary Complaints:

___ Vomiting ___ Blood in stool ___ Painful ___ Coughing
___ Growth/Lump ___ Anorexia ___ Diarrhea ___ Hair loss
___ Difficulty Breathing ___ Itching ___ Lethargic ___ Inappropriate
___ Increased thirst ___ Sneezing ___ Ears Urination
___ Blood in urine ___ Eyes ___ Difficulty Urinating ___ Lameness/Limping
____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 all that apply)

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 Last meal time:_____

What is your pet's diet? _____
Is your pet current on vaccinations? ___Yes ___No If yes Date given?_____
Any previous illness/surgery? _____
Is your pet on any medications/flea control? (list) _____
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 Union Animal Hospital to evaluate and treat my pet. I further acknowledge that my pet must be picked up by 6pm and that any balance for services and treatments rendered may be charged to the card on file if other payment options are not provided. I understand that should I fail to pick my pet up I will be responsible for any further fees to provide the necessary care to my pet. I understand Union Animal Hospital is not staffed on weekends, holidays or after 6pm and my pet may have to be relinquished to SCRAPS unless prior arrangements are made should I fail to pick up my pet before closing for their safety.

Signature of Owner/Agent_____Date_____

Primary Phone No. today_____ Name of Contact_____

Alternate Phone No 1.)_____2.)_____