Date:_____

Patient Drop-Off Form

Emergency Contact Number:_____

Client Information:

Name: _____

Additional contact(s):_____

Authorized to make financial decisions: ◯Yes ◯ No

Ideal pick-up time: ◯11:00-12:30 ◯3:30-4:00 ◯5:00-5:45

Note: This does not guarantee your pet will be ready at this time; however, we will do our best to accommodate your schedule and have your pet ready during your ideal pick-up time. Emergencies do happen and our patients will be seen and treated based on the severity of their condition.

Patient Information:

Name:_____

Gender:__M/F___ Spayed/Neutered:__Y/N__

If intact female, date of last heat cycle:_____

Age or Birthday:_____

Current Medications and Supplements:

- please list name, amount, frequency, and last dose of each:

_____

_____

Have there been any changes at home (diet, litter, schedule/routine, people living in home)? __Y/N__

Current Diet:_____ Amount per feeding:_____ Frequency fed:_____

Reason for Drop-Off:_____

Please check all that are abnormal:

◯Appetite ◯ Drinking ◯Urination

◯Defecation ◯Ambulation/walking ◯Activity level

◯Mentation/attitude ◯Vision ◯Hearing

◯Vocalization ◯Other_____

For any checked above, please describe how it is abnormal:_____

_____

_____

Date:_____

Duration of abnormalities:_____ ◯Hours ◯Days ◯Months ◯Years

Please check all clinical signs noted at home:

◯Seizures	◯Diarrhea	◯Vomiting
◯Coughing	◯Sneezing	◯Staggering/ataxia
◯Limping/lameness	◯Nasal discharge	◯Ocular (eye) discharge
◯Debris/odor in ear	◯Head shaking	◯Change in color of urine or feces
◯Increased eating	◯Increased drinking	◯Increased frequency of urination
◯Aggression	◯Hiding/Timidity	◯Increased frequency of defecation
◯Mass/growth	◯Wound/laceration	◯Blood in urine or feces
◯Trauma	◯Change in coat	◯Other_____

For any checked above, please describe in more detail (eg: frequency, color, odor, consistency, which leg/eye/ear, etc):_____

_____

_____

Duration of clinical signs:_____ ◯Hours ◯Days ◯Months ◯Years

By signing this document I agree that the information provided above is correct to the best of my knowledge, I am at least 18 years of age, and I am both legally and financially responsible for the aforementioned pet or an authorized agent for the pet owner. I permit the staff at South Willow Animal Hospital to examine, diagnose by way of performing pertinent tests, and treat my pet. I understand that any recommendations for services as well as any updates on my pet's status will be communicated to me by way of the phone number listed on this form. If I am unreachable I authorize the staff of South Willow Animal Hospital to make a medical judgment and proceed with diagnostics or treatments as pertinent to my pet's condition. I understand that I am financially responsible for said services and will pay in full at the time of my pet's discharge from the hospital.

In the event of complications in my pet's condition, I authorize South Willow Animal Hospital to take the appropriate measures in attempt to save my pet and I agree to be financially responsible for the charges. **Please resuscitate _____**

In the event of complications in my pet's condition, **do not resuscitate_____**

Client or Authorized Agent:_____ Date:_____

Signature

Client or Authorized Agent:_____

Printed Name