



Drop Off Form

Client Name:

Patient Name:

Client ID:

Species:

Client Address:

Breed:

Sex:

Phone Number:

Weight:

What will we be seeing your pet for today?

When did this start? _____ Is it a new problem or previous history of it? _____

What is the best phone number number to reach you at today? _____

Primary Complaints:

Vomiting Blood in urine Itching Hair Loss Coughing Sneezing
 Diarrhea Blood in stool Eyes Ears Painful Lethargic
 Difficulty Breathing Lameness/Limping Inappropriate Urination Growth/Lump
 Increased Thirst Difficulty Urinating Ultrasound by Dr. Drake

Other: _____

If your pet has any unusual lumps, bumps, wounds, or skin irritation that you would like the doctor to address today, please note the location(s) here:

Was your pet fed today? YES or NO

Time of last meal? _____

Is your pet current on vaccinations? YES or NO

Previous veterinary hospital (New Client Only): _____

Any previous injury or illness? _____

Is your pet on any medications? _____

Is your pet on heartworm and flea/tick medication? YES or NO Last given: _____

What type of food is fed? _____ How much/often? _____

What type of treats are fed? _____

Any other issues you would like addressed today? _____



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Please read and check one the following:

If doctor recommended, we may need to perform labwork depending on symptoms.

Yes, please run the tests No, not at this time Please call me first

If doctor recommended, we may need to perform diagnostic testing, such as x-rays.

Yes, please run the tests No, not at this time Please call me first

If doctor recommended, we may need to perform fluid therapy procedures, such as IV Catheter and IV fluids.

Yes, please proceed No, not at this time Please call me first

Please read and initial the following:

Authorization to provide care:

• In order to diagnose and treat many problems, blood tests, x-ray's and other diagnostics may be needed. If the cost exceeds what you have authorized, we will call you to discuss the recommendations prior to proceeding. In the event of a life-threatening condition, we will make every attempt to stabilize your pet and notify you as soon as possible.

• Please make certain we have a phone number where you may be reached.

• We do not offer overnight care so please be prepared to pick your pet up prior to our closing time.

• In admitting my pet to Southpaw Animal Health I authorize the veterinarians and their support staff to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.

I authorize up to \$_____ in diagnosis and treatment if needed.

Please read and initial an option below:

If complications should develop and my pet stops breathing and/or heart stops while in hospital, I elect the following and assume financial responsibility for my choice: (initial one below)

____ CPR (if initiated, charges may range up to or more \$200) ____ DNR

Client Signature: _____ Date: _____

Technician Initials: _____ (hospital usage)