Reviewed By: _____
Date: _____

Weight: _____

# B.E.S.T. VETS Animal Hospital

## Drop off Treatment Form

Patient: Owner: Date: Breed Sex: Age:

**Our anaimal must be current with vaccinations (K9: DHPP, Rabies, Bordetella, Influenza or Feline: Rabies, FVRCP) and negative of fleas, or Capstar will be given by mouth to kill fleas on animal for up to 24 hours, in order to be admitted to the hospital for treatments. This ensures that animal is protected from infectious diseases that can be transmitted in a hospital environment. _____(initial)**

What will we be seeing your pet for today?

_____

_____

_____

Primary Complaints:

____ Vomiting ____ Anorexia ____ Diarrhea ____ Changes in urine/urination ____ Painful ____ Lethargic
____ Changes in stool/defecation ____ Coughing ____ Sneezing ____ Hairloss ____ Growth/Lump ____ Ears
____ Difficulty Breathing ____ Eyes ____ Itching ____ Lameness/Limping

Other: _____

Please explain any of the above items marked: _____

_____

_____

_____

Has your pet had an increase or decrease in any of the following: (Please Circle)

| | | | | |
|---|---|---|---|---|
| **Drinking** | Increased | Decreased | No Change | Explain: _____ |
| **Appetite** | Increased | Decreased | No Change | Explain: _____ |
| **Urination** | Increased | Decreased | No Change | Explain: _____ |
| **Defecation** | Increased | Decreased | No Change | Explain: _____ |
| **Weight** | Increased | Decreased | No Change | Explain: _____ |

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

Is your pet current on vaccinations? _____ Date given? _____

Any previous illness/surgery? _____

Is your pet on any medications/flea control? (List) _____

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What is your pet's diet? _____

Any other issues you would like addressed?

_____

_____

_____

Please read and initial ONE of the following:

_____ I authorize testing and treatment and place no limit on additional charges/services deemed necessary by the veterinarian.

_____ 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 and/or diagnostics deemed necessary by the veterinarian.

_____ Please call me with an estimate before performing any additional procedures. I understand that if I cannot be reached, my pet will receive NO treatments, except in the case of an emergency.

Please read and initial the following:

_____ I hereby give my consent to B.E.S.T. VETS Animal Hospital to perform a physical exam and any approved diagnostics or treatments.

_____ In the event my pet has to stay overnight, I understand that they will not be monitored during the overnight hours and I have the option to take them to the VEC for overnight care

****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**_____ (Cardiopulmonary Resuscitation) **DNR**_____ (Do Not Resuscitate)

Owner/Agent Name: _____

Signature of Owner/Agent_____

Date_____ Primary Phone No. Today_____

Emergency Contact: _____ Phone: _____

In the event I cannot be reached, I authorize the above emergency contact to make medical decisions for my pet and understand I will be financially responsible for any fees incurred as a result of those decisions. _____ (initial)