Drop Off Treatment Form

Patient _____ Owner _____ Date _____
Breed _____ Sex M MC F FS Age _____ New Client Yes/ No

What will we be seeing your pet for today? _____

Primary Complaints:
___ Vomiting ___ Blood in urine ___ Itching ___ Painful ___ Diarrhea ___ Coughing ___ Hairloss
___ Growth/Lump ___ Blood in stool ___ Sneezing ___ Lethargic ___ Ears ___ Inappropriate Urination
___ Difficulty Breathing ___ Anorexia ___ Eyes ___ Difficulty Urinating ___ Lameness/Limping
___ Increased thirst ___Other: _____
Left (Back) Right Right (Belly) Left
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 one)*
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 Time of meal? _____
Is your pet current on vaccinations? _____ Date give? _____
Any previous illness/surgery? _____
Is your pet on any medications/flea control? (list)
_____
What is your pet's diet? _____
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 Veterinary Medical Center of Clayton/ Old Peachtree Animal Clinic to perform an exam and treatment(s).
Signature of Owner/Agent_____ Date_____
Primary Phone No. Today_____
Name of Contact_____
Alternate Phone No. 1)_____
2) _____