

Drop Off Form – Coddle Creek Animal Hospital

The information requested will tell us the things you want us to do for your pet. It is the only way we can be certain that we understand what you want. Therefore, it is very important for you to be as specific as possible. If we need additional information, we can reach you at the number you give us today. Thank you.

Owner's Name _____ Date _____
 Is address & phone number on medical record still correct? Yes No Changes: _____
 Pet's Name _____ Breed _____ Sex _____ Age _____

Phone Number You Can Be Reached At TODAY? _____
 Is your pet sick? Yes No Major Complaint? _____ When? _____
 Has pet been treated for same condition recently? Yes No How Long? _____

Current diet _____ No. feedings per day _____ Is the pet given table scraps? Yes No
 Diet supplement given: _____ Is Dog on Heartworm Preventive? Yes No

Note Services Requested Today

- | | |
|--|-----------------------------------|
| Vaccinations: | All Needed |
| Dogs: | Cats: |
| <input type="checkbox"/> DHLP+Parvo | <input type="checkbox"/> FVR |
| <input type="checkbox"/> Corona Virus | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Bordetella Bronchitis | <input type="checkbox"/> FIV |
| <input type="checkbox"/> Rabies | <input type="checkbox"/> Rabies |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

History

- | | | |
|---|--|-----------------|
| Any injury or accident in past 30 days? | <input type="checkbox"/> Yes <input type="checkbox"/> No | What? _____ |
| Had any surgery in the past 30 days? | <input type="checkbox"/> Yes <input type="checkbox"/> No | What? _____ |
| Allergic to any medications? | <input type="checkbox"/> Yes <input type="checkbox"/> No | What? _____ |
| Currently on any medications? | <input type="checkbox"/> Yes <input type="checkbox"/> No | What? _____ |
| Appetite normal? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Vomiting? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Diarrhea? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Listless? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Drinking more or less water than usual? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Weakness? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Coughing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Sneezing? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Gagging? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Urinating more or less than usual? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Scratching? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Shaking head? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Limping? Which leg? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Scotting? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| History of seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |
| Unusual lumps or bumps? | <input type="checkbox"/> Yes <input type="checkbox"/> No | How Long? _____ |

I understand that state law requires rabies vaccination for all pets.
 I also understand clinic policy requires Distemper/ Parvo, and Bordetella vaccination for dogs and / or Feline Distemper vaccine for cats be current.
 If my pet bites another animal or person while at this veterinary clinic, I will provide written evidence of a current rabies vaccination within 24 hours of notification to do so.
Date: _____ **Owner/Agent Initial** _____

Tests and Services

- | | |
|---|---|
| <input type="checkbox"/> Physical Exam | |
| <input type="checkbox"/> Internal Parasite Exam | Bad breath? <input type="checkbox"/> Yes <input type="checkbox"/> No How Long? _____ |
| <input type="checkbox"/> Deworm, if needed | Weight Loss or gain? <input type="checkbox"/> Yes <input type="checkbox"/> No How Long? _____ |
| <input type="checkbox"/> Combo Test (Felv/FIV) | Unusual discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No How Long? _____ |
| <input type="checkbox"/> Heartworm Test | Behavioral changes? <input type="checkbox"/> Yes <input type="checkbox"/> No How Long? _____ |
| <input type="checkbox"/> Bath | Is pet spayed / neutered? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Dentistry | Did pet eat this morning? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Surgery | Anything else we need to know? <input type="checkbox"/> Yes <input type="checkbox"/> No What? _____ |

Some pets require sedation for adequate physical exam, treatment, surgery or dentistry.
 May we sedate your pet if necessary? Yes No Call first
 After examination by the Doctor, may we proceed with tests and / or treatment? Yes No Call first

OWNER RELEASE: You are to use all reasonable precaution against injury, escape, or death of my pet. The clinic and staff will NOT be held liable for any problems that develop provided reasonable care and precautions are followed. In understand that ANY problem that develops with my pet while I'm absent will be treated as deemed best by the staff veterinarians and I ASSUME FULL RESPONSIBILITY for the treatment expense involved. If I neglect to pick up my pet within 5 days of the date below and do not notify you within that time frame you may assume that the pet is abandoned and are hereby authorized to dispose of the pet as you deem best and/or necessary.

DATE: _____ Owner/Agent : _____