DROP OFF TREATMENT FORM

Your Name: _____ **Phone where you can be reached:** _____

Date: _____ **Pet's Name:** _____ **Pet's Age:** _____

Choose one: ☐ Dog ☐ Cat **Choose One:** ☐ Spayed ☐ Neutered ☐ None-Intact

Please provide as much information and as accurately as you can to help us better provide your pet with care.
If you do not know the answer-please indicate that.

What are we seeing your pet for today? _____

What are the symptoms you are seeing? _____

How long has the problem been going on? _____

Is it getting better, worse or staying the same? _____

Primary Complaints: (*Mark all applicable*)

☐ Vomiting ☐ Blood in Urine ☐ Itching ☐ Painful ☐ Diarrhea ☐ Coughing ☐ Hair loss

☐ Ears/Eyes ☐ Blood in Stool ☐ Sneezing ☐ Lethargic ☐ Inappropriate Urination

☐ Difficulty Breathing ☐ Lameness/Limp ☐ Difficulty Urinating ☐ Growth/Lump

Has your pet had an increase or decrease in any of the following? *(Answer all)*

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

Energy: ☐ Increased ☐ Decreased ☐ No Change

Time of your pet's last meal:_____ am / pm

Is your pet current on vaccinations: ☐ Yes ☐ No ☐ Please vaccinate if healthy enough to do so

Has your pet been seen by another veterinarian for treatment: ☐ Yes ☐ No ☐ Dates: _____

May we call for records? ☐ Yes ☐ No Name of Clinic: _____

What do you feed your pet? (Include treats) _____ How Often: _____

Any known food allergies: ☐ Yes ☐ No If yes, please list:_____Is your pet on any medications:☐ Yes ☐ No If yes, Name of the medication(s)? _____

How often is medication given: _____ Dose of medication? _____

Is your pet allergic to any medications:☐ Yes ☐ No If yes, what is the name of the medication: _____

Has your pet had any surgery, illness or trauma (such as hit by car, falling great height, etc.) that could be connected to the current problem? ☐ Yes ☐ No If yes, when did said event(s) occur? _____

Is your pet on flea/tick/heartworm prevention: ☐ Yes ☐ No Last time prevention was given: _____

If yes, name of the prevention(s)? _____

What is the date of your pets last deworming? _____

Has your pet been previously diagnosed with any illness/disease? ☐ Yes ☐ No

If yes, explain _____

Do you have any other pets at home? ☐ Yes ☐ No Are they exhibiting any symptoms ☐ Yes ☐ No

If yes, explain _____

I am the owner or agent for the owner of the animal(s) described on this form and have the authority to execute this consent. I request that the veterinarian, agents and employees of Vienna Veterinary Clinic perform the services which are necessary to the examination, medication and treatment of the animals specifically described and identified on this form. I understand if the veterinarian finds it necessary to anesthetize my pet for treatment/diagnosis, etc. the fee for anesthesia is $90. I understand also that there is always a risk associated with any anesthesia episode, even in apparently healthy animals and have discussed my concerns with the veterinarian. I understand that it may be necessary to provide medical and/or surgical procedures which are not anticipated for the safety or care of my pet. I hereby consent to and authorize procedures such as hospitalize, sedate, anesthetize, prescribe medication, X- ray, and/or perform any treatment as are necessary in the veterinarian's best professional judgement. By signing below, I am authorizing the veterinarian on duty (and the assistants they designate) to examine the animal(s) and to administer medical treatment or emergency surgical treatment which is considered therapeutically and/or diagnostically necessary on the basis of the findings during the course of the examination. I understand no staff will be attending to my pet overnight (pets needing special care may be referred to a 24 hour hospital). I further understand that any animal found to be infected with either external or internal parasites will be treated for the same at my expense. I understand that the treatment of the patient will be conducted with due care and in accordance with the prevailing standards of competency in Veterinary Medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by the veterinarian, agent or employees of Vienna Veterinary Clinic. I accept responsibility for any result in additional charges. I understand that I am required to leave a deposit in the amount of $250.00+. This covers an initial exam and the start of diagnostics. The doctor will do an initial exam and determine what treatment is needed. I agree to be responsible for any additional charges incurred while my pet is in the care of this facility and understand the remainder of my balance is due before my pet can be released from the hospital. In case of non-payment, I am aware that Vienna Veterinary Clinic will charge the cost of collecting the debt on the amount owed for services. This includes the collections company's charges, attorney's fees and interest of 1.5 % per month (18% ann). I also consent to the release of medical information.

Please understand that we may NOT contact you regarding the status of your pet prior to your **scheduled pickup time of 4:30 pm** unless there is a medical emergency. In the case of a medical emergency, we will contact you immediately.

Signature of Owner or Agent: _____ Date: _____

Signature of Witness: _____ Date: _____

Pick up time for your pet is at 4:30 TODAY. Please note that we reserve this time just for you, to ensure our staff can answer your questions and get your pet properly discharged into your care. Please let us know if this time will not work for your schedule so we can give you additional choices. 07/20