

**ILLNESS
DROP-OFF FORM**

Date: _____ Time: _____

Client Name: _____

Pet's Name: _____

1. Nature of illness or symptoms which you noticed: _____

2. When did the problem begin? _____

3. Is this a new or recurrent problem? _____

4. Appetite: _____ Drinking: _____
Bowels: _____ Urination: _____
Vomiting _____ Activity Level: _____
What food do you use? _____

5. Current medication/dosage/duration: _____

6. Are there any "lumps" or lesions for the doctor to check? _____
Where?

7. Before we contact you, may we perform the minimum tests indicated to accurately diagnose the problem? _____

8. Number at which you may be reached today: _____

9. VACCINATIONS: Proof of current vaccination is required at time of drop-off.

10. THIS HOSPITAL DOES NOT MAINTAIN A 24 HOUR STAFF

Note: There may be a fee for hospitalization while your pet is here for an examination, tests, or treatments.

Signature _____