DROP OFF FORM

Date: ________________________ Client #: ____________________

Owner's Name: ____

Phone Number where we can reach you today: ______________________________

Pet Name: ______________________ Breed: ________________________

Color: ______________________ Sex: ______________________

Reason for visit: ____

Duration of problem: ____

Is the problem getting better? ____________________ worse? __________________

Previous treatment(s):____

Have you noticed or has your pet been treated for any of the following: (Circle those that apply)
Coughing Sneezing Vomiting Diarrhea Runny nose Runny eyes

Problems going to bathroom? ____

Is your pet eating/drinking normally? ____

Has activity level increased/decreased? ____

Please describe symptoms, in detail. ____

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Do we have permission to do the following, if necessary?
Sedate? ______________ Draw blood and run tests? ________

Take X-rays? ______________

What time do you plan to pick up your pet? ____

The staff at Foothills Veterinary Hospital, P.C. will make every effort to accommodate your pet's needs. We will attempt to contact you, as needed, regarding your pet's condition. Thank you for placing your pet's care with us.

Signature: ______________________________________ Date: _________________________