

## DROP OFF FORM

Loving Touch Animal Center

Owner: \_\_\_\_\_  
Street: \_\_\_\_\_  
City/St/Zip: \_\_\_\_\_  
Home: \_\_\_\_\_  
Work: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Breed: \_\_\_\_\_  
Color: \_\_\_\_\_  
Sex: \_\_\_\_\_ Spayed or Neutered? \_\_\_\_\_  
Age: \_\_\_\_\_

The information requested would 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.

Reason for drop off: \_\_\_\_\_

Major Complaint? \_\_\_\_\_

When did this issue start? \_\_\_\_\_

Has pet been treated for same condition recently? Yes ( ) No ( )

When and what treatment was preformed? \_\_\_\_\_

Is your pet's condition improved? Yes ( ) No ( )

How has your pet's condition changed? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Dietary and Nutrition:**

Current diet? \_\_\_\_\_ Canned ( ) Dry ( )

Number of feedings per day? \_\_\_\_\_ How much is given at each feeding? \_\_\_\_\_

Is your pet's appetite normal? Yes ( ) No ( ) How Long? \_\_\_\_\_

Is your pet given table scraps? Yes ( ) No ( )

**General Health Questions:**

Vomiting? Yes ( ) No ( ) How Long? \_\_\_\_\_

Diarrhea? Yes ( ) No ( ) How Long? \_\_\_\_\_

Drinking more or less water than usual? Yes ( ) No ( ) How Long? \_\_\_\_\_

Urinating more or less than usual? Yes ( ) No ( ) How Long? \_\_\_\_\_

Weight loss or gain? Yes ( ) No ( ) How Long? \_\_\_\_\_

Weakness? Yes ( ) No ( ) How Long? \_\_\_\_\_

Coughing? Yes ( ) No ( ) How Long? \_\_\_\_\_

Sneezing? Yes ( ) No ( ) How Long? \_\_\_\_\_

Gagging? Yes ( ) No ( ) How Long? \_\_\_\_\_

Scratching ? Yes ( ) No ( ) How Long? \_\_\_\_\_

Shaking head? Yes ( ) No ( ) How Long? \_\_\_\_\_

Limping? Which leg? \_\_\_\_\_ Yes ( ) No ( ) How Long? \_\_\_\_\_

Scotting? Yes ( ) No ( ) How Long? \_\_\_\_\_

History of seizures? Yes ( ) No ( ) How Long? \_\_\_\_\_

Currently on any medications? Yes ( ) No ( )

Please list all including dosage and times given: \_\_\_\_\_

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Supplements given: \_\_\_\_\_

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**Vaccinations:**

Are your pet's vaccinations current? Yes ( ) No ( ) Given here or elsewhere?

For dogs only: Heartworm preventive? Yes ( ) No ( ) What kind? \_\_\_\_\_

Unusual lumps or bumps? Yes ( ) No ( )  
Location(s) : \_\_\_\_\_ Duration : \_\_\_\_\_

Bad breathe? Yes ( ) No ( ) How Long? \_\_\_\_\_

Unusual discharge? From where? \_\_\_\_\_ Yes ( ) No ( ) How Long? \_\_\_\_\_

Behavioral changes? Yes ( ) No ( ) What? \_\_\_\_\_

Any known allergies/sensitivities? Yes ( ) No ( ) What? \_\_\_\_\_

Anything else we need to know? Yes ( ) No ( ) \_\_\_\_\_

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**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 ( )**

**\*If we are unable to reach you, I authorize the treatment of my pet as deemed best by the staff veterinarians, and I assume full responsibility for the treatment expense involved.**

**Owner/Agent Initial** \_\_\_\_\_ **Date** \_\_\_\_\_

**Call the office by 3:30 p.m. to check on your pet's progress and in case we have not been able to get in touch with you.**

**OWNER RELEASE:** The clinic and staff will **NOT** be held liable for any problems that develop provided reasonable care and precautions are followed. I understand that ANY problem that develops with my pet while I am absent will be treated as deemed best by the staff veterinarians and I assume full responsibility for the treatment expense involved.

**Owner/Agent** \_\_\_\_\_ **DATE** \_\_\_\_\_

**RABIES NOTIFICATION:** I understand that state law requires rabies vaccination for all pets. I decline vaccination at this time because vaccinations have been given elsewhere and are 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.

**Owner/Agent** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Phone Number that you can be reached at today -** \_\_\_\_\_

**Are there any times today that we will not be able to reach you? Yes ( ) No ( )**

**If yes, please list times** \_\_\_\_\_