

Heritage Animal Hospital, Inc.

North Clinic Phone: (812) 466-1155 Fax: (812) 466-7692

South Clinic Phone: (812) 299-1131 Fax: (812) 298-0185

DROP OFF SHEET

Client Name: _____

Pet Name: _____

Weight: _____

Age: _____

*We have arranged for you to leave your pet here to allow a veterinarian to examine your pet as soon as possible today. Please read through the following questions and answer any that may apply to your pet today. **Please be as detailed as possible!** Please read and sign the authorization on the back of this form.*

1. Everything was okay with my pet until _____ .

Since then, _____

2. My pet is lethargic: _____ YES _____ NO

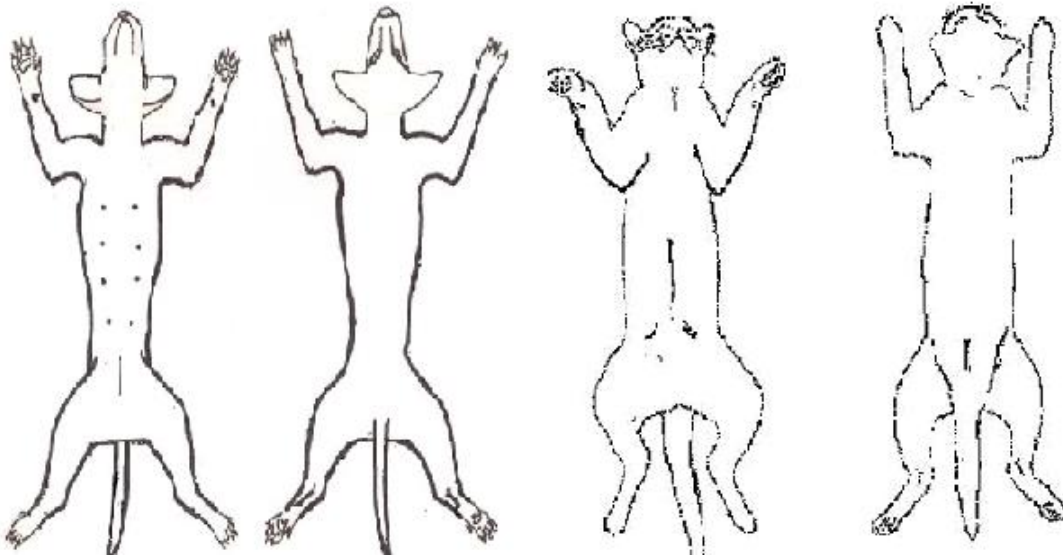
3. Water intake has: _____ Decreased _____ Increased _____ Not changed

4. My pet has not eaten since _____

5. My pet has been vomiting: _____ YES _____ NO
 If yes, when did the vomiting start? _____
 What color? _____
 What substance? _____
 When was the last time your pet vomited? _____
6. My pet has: _____ Normal Stools _____ Constipated _____ Diarrhea
 If you checked *constipated*, when was the last bowel movement? _____

 If you checked *diarrhea*, when did it start? _____
 What color? _____
 What consistency? _____
7. Has your pet had access to foods other than recommended pet food? _____
 If yes, what kind(s) of food(s) _____
 How often? _____
8. Do you feel your pet has _____ lost or _____ gained weight?
 Over what length of time? _____
9. My pet is: _____ lame _____ sore _____ injured
 I think his/her _____ is bothering him/her.
 This started: _____
 It has _____ worsened or _____ improved some since _____
 _____ This has never happened.
 _____ This has recently happened. When? _____
 _____ This is a long time/chronic problem. Since when? _____

Please add any other details related to your pet's injury/issue and circle the body part on the diagram (below) that you think is the problem _____



I am the owner/agent for described animal and I authorize and request an exam for my pet. I understand that sedation and/or pain medication will be provided if deemed reasonable. I understand a veterinarian will contact me after he/she has examined my pet to discuss recommended diagnostics and treatment, and will have an initial estimate of charges.

I can be reached at _____ . If I cannot be reached at this number, I authorize initial diagnostics, including radiographs, and blood work if indicated for my pet. Further, if I cannot be reached, I authorize initial treatment, including fluid support and other supportive medications be started as indicated for my pet.

I authorize anesthesia, surgery and medications if needed for abscesses, lacerations, or other wounds if my pet is presented for one of these problems. I understand, and accept, that when anesthesia is involved, there are always inherent risks, including death.

I understand payment is due when my pet is discharged, however, a deposit may be required after an estimate is prepared and discussed. I accept financial responsibility for charges incurred for this pet.

I understand that I will be charged for flea medication (a dose will be applied) if evidence of fleas is found on my pet today.

Signature: _____ Date: _____