Drop-off Appointments

Today's Date_____

Client Name: _____ Phone Number: _____

Patients Name: _____

PLEASE INITIAL THAT YOU HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES

✍ _____**I understand my pet has to be current on vaccinations to be dropped off for treatments. (Da2PCPV, Rabies for dogs and FVRCP, Leukemia, Rabies for cats)** ***Vaccinations will NOT be updated if the treating physician feels it may be detrimental to patient's health.***
Record of current vaccinations administered by veterinarians other than White Oaks Veterinary clinic must be on file at the time of admission for elective procedures. To avoid duplicate vaccinations please list the clinic and/or physician name and contact information so we may confirm and update records.

Clinic/Physician Name _____ Contact #_____

✍ _____**I understand that if my pet has parasites (Fleas or Ticks), patient will be treated to help prevent them from compromising their health and the health of others. I understand there is an additional charge for this based upon species of my pet and type of parasite(s).**

Name of contact *(owner/guardian)* _____ **Phone Number**_____

Call contact listed above before performing any diagnostics. Yes_____ No_____

OR

I authorize the following diagnostics to be preformed if the treating Physician feels it beneficial in the diagnosis of medical conditions.

_____Yes _____Decline : Fecal
_____Yes _____Decline :Radiographs
_____Yes _____Decline :Bloodwork (Example:CBC/Chem/Electrolytes, FIV/LEUK, Heartworm Test, Tick Panel)

Symptoms my pet has been having:

_____
_____
_____

How long has patient been experiencing symptoms? _____

Is patient currently on any medication?
No____ Yes_____ If yes, describe_____

Does patient live with other pets?
No___ Yes___ If yes, describe_____

Have you used chemicals *(example: pesticides, fertilizers*) in home, on lawn or put out rodent bait?
No____ Yes_____ If yes, describe_____

What kind of food does your pet eat? Brand, type (dry/canned), home diet, table scraps:
_____

Has patient been treated for these symptoms before?
No____ Yes_____ If yes, describe_____

Does patient live Indoors____ Outdoors____ Indoor/Outdoor____

Is patient on heartworm preventative? No____ Yes____

Anything else: _____