



Drop-Off Admission Form

Patient Name: _____

Owner's Name: _____

Preferred contact phone number: _____

Secondary contact name, in case you cannot be reached: _____

Secondary contact phone number: _____

Medical History

My pet's diet (brand of food) and how much are they fed: _____

My pet's behavior is: **Normal** **Abnormal** **Describe:** _____

My pet's stools are: **Normal** **Abnormal** **Describe:** _____

My pet's urinary habits are: **Normal** **Abnormal** **Describe:** _____

My pet's food intake is: **Normal** **Increased** **Decreased** **Last Ate:** _____

My pet's water intake is: **Normal** **Increased** **Decreased** **Last Drank:** _____

Does your pet take over the counter or prescription medications? **Yes** **No**

If yes, please list the medications: _____

Why are we seeing your pet today?

Wellness - Preventative Care (below)

Illness (pg. 2)

Wellness - Preventative Care:

Annual/Bi-Annual Testing: **All Due** **Heartworm Test** **Intestinal Parasite Screen**
 FeLeuk/FIV **Vaccine Titers** **Annual/Bi-Annual Blood Work**

Canine Vaccines: **All Due** **Rabies** **Distemper/Adenovirus/Parvovirus** **Leptospirosis**
 Bordetella/Upper Respiratory **Influenza**

Feline Vaccines: **All Due** **Rabies** **FVRCP - Respiratory** **Leukemia**

Parasite Prevention: **All Due** **Flea & Tick** **Heartworm** **Intestinal Parasites**

Any other care, services, or medications needed for your pet's visit today?

Illness or Medical Concern:

Date Illness/Injury occurred: _____

Please describe Illness or Medical Concern:

Has your pet been vomiting or having diarrhea? **No** **Yes** How Long: _____ Color: _____ Substance: _____ Last Occurrence: _____

Does your pet have access to food other than own pet food? **No** **Yes** What kind? _____

Has your pet been limping? **No** **Yes** Which limb(s): _____ How Long: _____

Injury details: _____

Additional Authorizations

It is important that our hospital is able to reach the owner or person responsible for making decisions for the animal if anything occurs that is not planned or estimated.

Please be aware during a life and death situation we will follow the signed Cardiopulmonary Resuscitation Form before calling for additional authorizations.

Please circle **one option** to help us efficiently care for your pet in a timely manner.

Please perform whatever medical procedures the Doctor deems necessary for the best possible care of my pet.

I authorize up to \$175.00, \$250.00, Other \$ _____, in additional procedures.

Please call with estimate before any additional procedures are performed.

Any pets staying in the hospital, for any reason, are required to be free of fleas, ticks, or any other external parasites. If the staff finds any parasites on your pet, we will administer parasite control at the owner's expense.

Initials _____

I hereby authorize Advanced Care Veterinary Hospital and its staff to receive, prescribe for, vaccinate, and/or treat the animal listed on page 1, as needed for the health and well-being of the animal.

Furthermore, I agree to pay for services rendered at the time the pet is discharged from the hospital.

Owner/Agent Signature: _____ Date: _____