



Deepwood Veterinary Clinic, Inc.
Patient Drop-Off Release Form



Owner's Name: _____ Pet's Name: _____ Pet's Age: _____

New Address? Yes No Updated Address: _____

New Phone #? Yes No Updated Phone: _____

Reason for Visit:

Please Explain:

Exam/Vaccination History:

| <u>Dog</u> | <i>Is Current:</i> | <i>Needs Update:</i> | <u>Cat</u> | <i>Is Current:</i> | <i>Needs Update:</i> |
|-------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|
| WELLNESS EXAM | <input type="checkbox"/> | <input type="checkbox"/> | WELLNESS EXAM | <input type="checkbox"/> | <input type="checkbox"/> |
| DISTEMPER (DHLPP) | <input type="checkbox"/> | <input type="checkbox"/> | DISTEMPER (FVRCP) | <input type="checkbox"/> | <input type="checkbox"/> |
| RABIES | <input type="checkbox"/> | <input type="checkbox"/> | RABIES | <input type="checkbox"/> | <input type="checkbox"/> |
| CANINE INFLUENZA | <input type="checkbox"/> | <input type="checkbox"/> | FELINE IMMUNE - | | |
| BORDETELLA | <input type="checkbox"/> | <input type="checkbox"/> | DEFICIENCY TEST | <input type="checkbox"/> | <input type="checkbox"/> |
| HEARTWORM TEST | <input type="checkbox"/> | <input type="checkbox"/> | FELINE LEUKEMIA | <input type="checkbox"/> | <input type="checkbox"/> |
| FECAL | <input type="checkbox"/> | <input type="checkbox"/> | FECAL | <input type="checkbox"/> | <input type="checkbox"/> |

Medical History:

Yes or No

- Did your pet eat today? If yes, when? _____
- Is your pet on Heartworm preventative?
 Do you need a refill? Y N Months of prevention requested (please circle): 6 12
- Is your pet on Flea/Tick preventative?
 Do you need a refill? Y N Months of prevention requested (please circle): 6 12
- Has your pet ever had any reaction to medications?
 Which? _____
- Has your pet ever had any reaction to vaccines?
- Has your pet ever had any reaction to anesthesia?
- Is your pet currently taking any medications?
 Name: _____ Dose/Frequency: _____
 Name: _____ Dose/Frequency: _____
 Name: _____ Dose/Frequency: _____
- Is your pet taking any Over the Counter supplements?
 Name: _____ Dose/Frequency: _____
 Name: _____ Dose/Frequency: _____
 Name: _____ Dose/Frequency: _____

Has your pet shown any of the following symptoms?

- Vomiting: Duration: _____ # times/day: _____
Vomited (*please circle*): Food Phlegm Bile Unknown Other _____
- Diarrhea: Duration: _____ # times/day: _____
Stool contained (*please circle*): Mucus Blood Unknown
Stool color: _____
- Straining to have a Bowel Movement: Duration: _____
- Straining to Urinate: Duration: _____
- Scooting: Duration: _____
- Coughing: Duration: _____
Is anything being coughed up? Please describe: _____
- Gagging: Duration: _____
- Scratching: Duration: _____ What part of body? _____
- Seizures: Duration: _____ Frequency: _____
- Limping: Duration: _____ Which leg(s)? _____
- Unusual Lumps or Bumps: First Noticed: _____ Where? _____
- Urinating [more / less] than normal Duration: _____
- Drinking [more / less] than normal Duration: _____
- Noticeable [loss / gain] in weight Duration: _____
- Eating [more / less] than normal Duration: _____
- Listless, lethargic: Duration: _____
- Weakness in limbs Duration: _____
- Shaking head Duration: _____

| | |
|---|---|
| <u>Services to be Performed:</u> | |
| <input type="checkbox"/> Diagnostic Exam | <input type="checkbox"/> Annual Wellness Exam |
| <input type="checkbox"/> Puppy/Kitten Wellness Exam | <input type="checkbox"/> Heartworm Test |
| <input type="checkbox"/> FELV/FIV Test | <input type="checkbox"/> Vaccines |
| <input type="checkbox"/> Blood work | <input type="checkbox"/> Intestinal Parasite Exam |
| <input type="checkbox"/> Grooming <input type="checkbox"/> Bath | <input type="checkbox"/> Flea/Tick Treatment |
| <input type="checkbox"/> Microchip | <input type="checkbox"/> Other: _____ |

If deemed medically necessary by the Doctor, I authorize the following care for my pet:

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| Diagnostic blood work - (\$50-150) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Urinalysis - - - - - (\$45-50) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Radiographs (X-Rays) - (\$75-150) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ultrasound - - - - - (\$75-150) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sedation - - - - - (\$28-50) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Emergency Contact Number: _____
(*Please provide a number where you can be reached immediately*)

Signature: _____

Date: _____

Witness: _____

Date: _____