

PET DROP OFF INFORMATION

Client Name: _____ Pet's Name: _____

Telephone Number to reach you today: _____

Has your pet been seen by us before? ☐ Yes ☐ No (if not, please fill out a Client Registration form)

When was your pet's last meal? _____ What did he/she eat? _____

What medications (if any) has your pet received in the last 24 hours?

Name of medication	Amount given	What time

Is your pet sensitive or allergic to any medications or food, vaccinations or anesthesia? ☐ no ☐ yes

(Please list) _____

What vaccinations, if needed, would you like us to give your pet today?

☐ Rabies ☐ Feline upper respiratory ☐ Feline Leukemia

Please check off the problem(s) your pet is having, and detail any pertinent history leading up to the current condition, and any previous major medical problems.

- | | | | |
|-----------------------------------|---|---|--|
| ☐ Vomiting | ☐ Increased thirst | ☐ Decreased thirst | ☐ Limping |
| ☐ Diarrhea | ☐ Increased Urine output | ☐ Decreased urine output | ☐ Urinating out of the litter box |
| ☐ Coughing | ☐ Increased appetite | ☐ Decreased appetite | ☐ Defecating out of the litter box |
| ☐ Sneezing | ☐ Increased activity | ☐ Decreased activity | ☐ Skin problem ☐ Other |

Name of previous Veterinary clinic if this is a referral or second opinion appointment:

PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED

I am the responsible individual and authorize the veterinarians of **The Scaredy Cat Hospital**, and their support staff to administer treatment and/or perform such diagnostic or surgical procedures as listed on the estimate and consent for treatment form.

Signed: _____ **Date:** _____

The Scaredy Cat Hospital
4731 E. Greenway Rd. STE 9
Phoenix, AZ 85032
602-494-7000
602-867-7094 (Fax)