



## DROP-OFF TREATMENT CONSENT FORM

**OWNER'S NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PET'S NAME:** \_\_\_\_\_ **SEX:** \_\_\_\_\_ **BREED/COLOR:** \_\_\_\_\_

**PHONE NUMBER WHERE YOU MAY BE REACHED TODAY:** \_\_\_\_\_

**Drop-offs are worked into the schedule as soon as possible.** We know how concerned you are about your family member, and we will call you as soon as an examination has been performed to let you know the findings and when your pet can go home.

**Reason for Today's Visit:** \_\_\_\_\_

**If Due to an Illness, Please Describe Problem:** \_\_\_\_\_

**Duration of Problem:** \_\_\_\_\_

**Is the Problem Getting Worse, Better, or No Change:** \_\_\_\_\_

**Please List Any Previous Treatments For This Problem:** \_\_\_\_\_

**PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED:**

- |                      |             |                     |                    |                |            |
|----------------------|-------------|---------------------|--------------------|----------------|------------|
| Vomiting             | Diarrhea    | Constipation        | Frequent Urination | Coughing       | Lethargy   |
| Difficulty Breathing | Sneezing    | Eating More         | Eating Less        | Drinking More  | Bad Breath |
| Drinking Less        | Weight Gain | Weight Loss         | Itching/Chewing    | Hair Loss      |            |
| Limping              | Fleas/Ticks | Ear Discharge/Smell | Eye Discharge      | Pain/Stiffness |            |

**Please indicate any additional services you would like to have performed. (Initial Below):**

Nail Trim \_\_\_\_\_ Bath \_\_\_\_\_ Vaccinations \_\_\_\_\_ Express Anal Glands \_\_\_\_\_ Clean Ears \_\_\_\_\_  
 Pull Ear Hair \_\_\_\_\_ Other (please describe): \_\_\_\_\_

**IF MEDICALLY NECESSARY, DO WE HAVE PERMISSION TO:**

**Sedate your pet?** (Please INITIAL Your Choice:) Y \_\_\_\_\_ N \_\_\_\_\_ CALL FIRST \_\_\_\_\_

**Take X-Rays?** (Please INITIAL Your Choice:) Y \_\_\_\_\_ N \_\_\_\_\_ CALL FIRST \_\_\_\_\_

**Run Bloodwork/Diagnostic Tests?** (Please INITIAL Your Choice:) Y \_\_\_\_\_ N \_\_\_\_\_ CALL FIRST \_\_\_\_\_

I am the owner or agent of the above described animal, I am at least 18 years of age, and I have the authority to execute this consent. I understand that Animal Family Practice requires my pet to be free from internal and external parasites and up to date on all vaccinations. I understand that I am financially responsible for all medical and surgical procedures and treatments, as well as for any cost associated with vaccination or parasite treatment and that this payment is due upon discharge. I understand that during the performance of the aforementioned medical and surgical procedure(s) and treatment(s), unforeseen conditions may be revealed that necessitate an extension of the aforementioned medical and surgical procedure(s) and treatment(s) than those set forth above, which may result in a change in the estimated cost. Therefore, I hereby consent to and authorize the performance of such medical and surgical procedure(s) and treatment(s) as are necessary and desirable in the exercise of the veterinarian's professional judgment. I also authorize the use of appropriate anesthetics and other medications and I understand that hospital support personnel will be employed as deemed necessary by the veterinarian. I have been advised of the nature of the medical and surgical procedure(s) and treatment(s) and the risks involved. I realize that results cannot be guaranteed. I have read and understand this authorization and consent. I hereby consent and authorize the veterinarians and staff of Animal Family Practice Veterinary Hospital to render treatment, and by signing below agree to all conditions. I certify that if I am signing as owner/agent, that I have the authority to execute this consent.

\_\_\_\_\_  
**SIGNATURE OF OWNER/AGENT/RESPONSIBLE PARTY** **DATE**

\_\_\_\_\_  
**WITNESS** **DATE**

For office use only: **PROOF VAX UTD?**  **K9:** RV DAPP/L BV  **FEL:** RV FVRCP ILL  **LIST VAX REQUIRED:**