Patient Drop-Off Form

Client: _____ Patient: _____
Emergency Contact Number: _____
Additional Authorized Contact(s): _____

Current Medications/Supplements (please list name, amount, frequency, and last dose):_____
_____
_____.

Current Diet:_____ Amount per feeding: _____

Frequency fed: _____

Reason for Drop-Off Today:_____

Please check all clinical signs noted at home:

☐Seizures ☐Diarrhea ☐Vomiting ☐Coughing ☐Sneezing ☐Staggering/ataxia
☐Limping ☐Nasal discharge ☐Eye discharge ☐Debris/odor in ear
☐Head shaking ☐Change in urination ☐Change in appetite ☐Change in drinking
☐Trauma ☐Licking/chewing at paws ☐Aggression ☐Wound ☐Mass/growth
☐Blood in urine/feces ☐Change in hair coat
☐Other_____

For any checked above, please describe how it is abnormal and how long it has been occurring for:

_____
_____
_____
_____
_____.

By signing this document I agree that the information provided above is correct to the best of my knowledge, I am at least 18 years of age, and I am both legally and financially responsible for the aforementioned pet or an authorized agent for the pet owner. I permit the staff of Paw Prints Animal Hospital to examine, diagnose by way of performing pertinent tests, and treat my pet. I understand that any recommendations for services as well as any updates on my pet's status will be communicated to me by way of the phone number listed on this form. If I am unreachable I authorize the staff of Paw Prints Animal Hospital to make a medical judgement and proceed with diagnostics or treatments as pertinent to my pet's condition. I understand that I am financially responsible for said services and will pay in full at the time of my pet's discharge from the hospital.

Please check one below:

In the event of complications in my pet's condition, I authorize Paw Prints Animal Hospital to take the appropriate measure in attempt to save my pet and I agree to be financially responsible for the charge. ☐ **Please Resuscitate**
In the event of complications in my pet's condition, ☐ **Do Not Resuscitate.**

Client or Authorized Agent: _____ Date:_____