



Drop-off Information

Owner's Name _____ Pet's Name _____ Date _____
Phone number(s) where you can be reached TODAY _____

REASON FOR VISIT TODAY _____

HOW LONG HAVE SYMPTOMS BEEN PRESENT? _____

Does your pet have any of the following?

- ☐ Vomiting? Food? Bloody? Related to feeding? _____
☐ Diarrhea? Describe bloody, clear, mucus, etc. _____
☐ Listless/Depressed?
☐ Changes in appetite (More or Less)?
☐ Weakness; trouble getting up; staggering?
☐ Coughing, sneezing or difficulty breathing?
☐ Scratching/Itching?
☐ Discharge from eyes, ears, nose? (circle which)
☐ Shaking head, scratching ears?
☐ Scooting? Straining to have bowel movement?
☐ Seizures? Describe _____
☐ Trouble urinating; blood in urine; leaking urine? Which? _____
☐ Drinking? More or less than normal? _____
☐ Limping? Which leg? _____
☐ Weight loss? Or Weight gain? _____
☐ Unusual lumps, bumps or swellings? Where? _____
☐ Unexplained pain? Can you tell where? _____
☐ Discharge from or irritation of vulva/penis/prepuce? _____
☐ Skin rash, sore, redness? Where? _____
☐ Any other symptoms not listed? _____

What do you feed your pet? _____ Is your pet indoor or outdoor? _____

May we sedate/anesthetize your pet if necessary? Yes ___ No ___ Please Call first _____

May we perform diagnostic tests if necessary? (x-rays, blood tests, etc) Yes ___ No ___ Call First _____

I understand there will be a partial-day hospitalization charge (\$12.00) Initial _____

I understand that in the course of treatment, x-rays, surgical procedures, sedation and/or anesthesia may be necessary. I authorize Circle of Life AWC to perform the necessary procedures. I fully understand the risks involved and realize that results cannot and will not be guaranteed. I am the owner or authorized agent for the owner and have full authority to execute this consent.

Signature _____ Date _____ COL Staff _____