



# Patient Drop-Off Form Illness

Pet's Name: \_\_\_\_\_

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary phone number to reach you at today: \_\_\_\_\_

Back up telephone number: \_\_\_\_\_

## **Request for Illness related care:**

Primary complaint(s): Please select all that apply to your pet's current condition.

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Behavior Problems    | <input type="checkbox"/> Gagging                       | <input type="checkbox"/> Sneezing     |
| <input type="checkbox"/> Bleeding gums        | <input type="checkbox"/> Hair Loss                     | <input type="checkbox"/> Shaking Head |
| <input type="checkbox"/> Blood in Stool       | <input type="checkbox"/> Lameness/Limping              | <input type="checkbox"/> Vomiting     |
| <input type="checkbox"/> Breathing problems   | <input type="checkbox"/> Increased Thirst              | <input type="checkbox"/> Weakness     |
| <input type="checkbox"/> Coughing             | <input type="checkbox"/> Itchy                         | <input type="checkbox"/> Weight Loss  |
| <input type="checkbox"/> Check growth         | <input type="checkbox"/> Increased Urination/Frequency | <input type="checkbox"/> Weakness     |
| <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Ingested foreign substance    | <input type="checkbox"/> Wound(s)     |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Loss of balance               | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Decreased Appetite   | <input type="checkbox"/> Not acting like self          | _____                                 |
| <input type="checkbox"/> Ear Problems         | <input type="checkbox"/> Painful                       | _____                                 |
| <input type="checkbox"/> Eye Problems         | Where _____  | _____                                 |

What is the duration of your pet's problem?

\_\_\_\_\_  
\_\_\_\_\_

What medications does your pet currently take and what do you feed them?

\_\_\_\_\_  
\_\_\_\_\_

Any other details you would like us to know about for today's drop off?

\_\_\_\_\_  
\_\_\_\_\_

**I hereby authorize the veterinarian and Back Bay Veterinary Clinic to examine, prescribe for, or treat the above described pet. I will assume responsibility for all charges incurred for the care of this animal. I also understand that these charges will be paid at completion of service or time of release and that a deposit of 50% is required for surgical and/or in-hospital treatments.**

Signature of Owner: \_\_\_\_\_ Date: \_\_\_\_\_