Hopi Animal Hospital
Drop off Treatment Form

Patient Name: _____ Date _____

What will we be seeing your pet for today? _____

***Primary Concerns**: check all that may apply if your pet is receiving an exam

☐ Vomiting	☐ Diarrhea	☐ Blood in stool	☐ Blood in urine	☐ Lethargic
☐ Ears	☐ Eyes	☐ Wound/Skin	☐ Hair loss	☐ Painful
☐ Vaccinations	☐ Growth/Lump	☐ Lameness/Limping	☐ Itching /Scratching	☐ Coughing/Sneezing
☐ Difficulty Breathing	☐ Weight Gain/Loss	☐ Eating/Drinking Increased/decreased	☐ Difficulty Urinating/Defecating	☐ Inappropriate Urination/Defecation
☐ Other:	please explain: _____			
☐ No Concerns				

How long have these symptoms and/or behaviors been persisting? _____

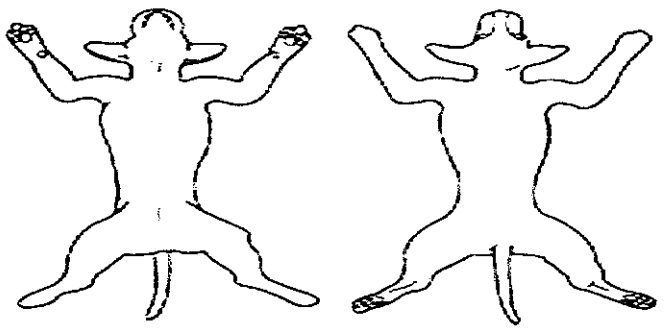
Please note location (if any) of primary complaint: (example: left front leg or right ear) _____

Does your pet have any unusual lumps, bumps, wounds, or skin irritation which you would like the doctor to address today?
If yes, please note location of each on the diagram:

☐ Yes ☐ No

How long they have been there? _____

Have they changed in size or color? _____



Was your pet fed today?	☐ Yes ☐ No	Diet: _____	
Is your pet on heartworm prevention?	☐ Yes ☐ No	Date given: _____	
Has your pet been seen elsewhere?	☐ Yes ☐ No	Where? _____	
**If so, may we call for records?	☐ Yes ☐ No	Phone #: _____	
Is your pet on any medication?(not prescribed here)	☐ Yes ☐ No	If yes, please list on back side	

With my signature hereunder, I hereby consent and authorize **Dr.** _____ and/or associates to perform procedures on my pet. I understand that this facility is not staffed beyond regular office hours. I understand and accept all risks involved. All costs of services are to be paid upon release of my animal. Estimates are available upon request.
***There are no refunds on dispensed medications, medical services, and/or medical devices (such as an E-Collar).*

Please initial the option you prefer below:

_____ **Perform exam and diagnostics/treatments deemed necessary without contacting me prior.**
* In addition to the exam and/or estimate, I approve up to: _____ $250 / _____ $500 / _____ Any amount necessary

_____ **Perform exam ONLY and call if any diagnostics/treatments are deemed necessary.**
* If we are unable to reach you, diagnostics/treatments will not be provided and may require future appointments and fees.

Print Name: _____ **1st Contact Number:** _____

Signature: _____ **2nd Contact Number** _____