

WesternU Pet Health Center Drop OFF & GO Wellness Visit

Today's Date: _____

OWNER'S INFORMATION

Owner's Last Name: _____ First: _____ Middle: _____

Pet's Name: _____ Email Address: _____

IMPORTANT: LIST A NUMBER YOU CAN BE REACHED AT TODAY

Mobile Number: () _____

Other Contact Number: () _____

Pick up time will be between 5-6pm unless otherwise indicated below:

PATIENT INFORMATION

The doctor will conduct a thorough nose-to-tail physical examination and confirm that your pet is healthy. Then, we recommend the services listed below in which, it is an additional fee that can be estimated to you by our reception staff. **PLEASE INDICATE YOUR APPROVAL BY CHECKING THE APPROPRIATE BOXES.**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaccinations	Vaccinations keep your pet healthy and free of disease. The doctor will give any vaccinations that are due unless otherwise indicated below:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fecal Tests	We will run your pet's fecal test in house, which includes microscope examination for intestinal parasites and worm eggs, and/or a possible Giardia parasite snap test if needed.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Tests	We recommend annual testing to detect common disease early, while treatment is most likely to be effective. Our blood tests are personalized for pets based upon age.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Parasite Prevention	We recommend regular deworming for the intestinal parasites that can infect humans, including roundworms and hookworms.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Flea/Tick/Heartworm Prevention	We recommend a monthly application of flea, tick and heartworm prevention

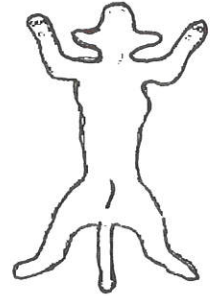
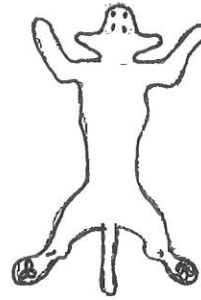
Does your pet have any allergic reactions or problems to vaccines, medications or anesthesia? If so please indicate below?

Has your pet been having any of the following problems?

<input type="checkbox"/> Coughing	<input type="checkbox"/> Increased/Decreased Appetite
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Increased/Decreased Water Intake
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Increased/ Decreased Urination
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Straining to Urinate or Defecate
<input type="checkbox"/> Constipation	<input type="checkbox"/> Cats, eliminating outside litter box
<input type="checkbox"/> Scooting Rear End on the Floor	<input type="checkbox"/> Other: _____

How many lumps total if any? _____

Top: Left Side Right Side Bottom: Right Side Left Side



Please describe the severity and duration of any problems noted above:

What kind of food does your pet eat? How much? How often?

Please list any medications your pet is taking, along with dose (number of pills or amount of liquid), and how often you give it:

I am the owner or agent for the owner of the animal described on this form and have authority to execute this consent. I request that the veterinarians, agents and employees of Western University Pet Health Center perform the services which are necessary to the examination, medication and treatment of the animals specifically described and identified on this form. I authorize the veterinarians on duty (and the assistants the designate) to examine the animals to administer medical treatment or emergency surgical treatment which is considered therapeutically and/or diagnostically necessary on the basis of the findings during the course of the examination. Therefore, I hereby consent to and authorize the performance of such procedure(s) as are necessary and desirable in the exercise of the veterinarian's professional judgment. I further understand that any animal found to be infected with either external or internal parasites will be treated for same at my expense. I understand that the treatment of the patient will be conducted with due care and in accordance with the prevailing standards of competency in veterinary medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by the veterinarians, agents or employees of Western University Pet Health Center. I assume financial responsibility for all the charges incurred for the services rendered and understand that full payment is required upon discharge. In case non-payment, I am aware the Western University Pet Health Center will charge the cost of collecting the debt on the amount of owed of services. This includes the collections company's charges, attorney's fees and interest pf 1.5% per month (18% annum).

Owners Initial _____ I understand that veterinary students may be involved with the examination and/or treatment of my pet, under the supervision of a veterinarian or Registered Veterinary Technician (RVT).

Owner Signature _____

Date _____