



St. Francis Animal Hospital- EXOTICS FORM

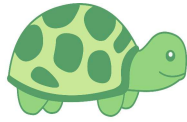
Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Drop Off Treatment

Owner's Name: \_\_\_\_\_

Email: [appts@sfah.net](mailto:appts@sfah.net) Phone: 706-860-6617

STAFF USE: Weight: \_\_\_\_\_ Temp: \_\_\_\_\_



What will we be seeing your pet for today?

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

Primary Complaints (Circle All that apply):

Vomiting	Diarrhea	Blood in Stool	Blood in Urine	Inappropriate Urination	Difficulty Urinating	Increased Thirst
Anorexia	Lethargic	Hair loss	Itching	Sneezing	Difficulty Breathing	Coughing
Eyes	Ears	Painful	Lameness/Limping: Left Front      Right Front		Left Rear	Right Rear
Growth/Lump/Wound Location:		<p><b>This form is your primary communication to the doctor. Please complete it thoroughly and note any concerns that need to be addressed today.</b></p> <p><b>*Drop Off Walk Ins Only: For Drop Off appointments we will call you as soon as we complete the exam to discuss treatment recommendations and discharge time.</b></p> <p><b><i>For exotics, we prefer that you remain in the parking lot until a doctor has initially assessed your pet. PLEASE NOTE THAT IF YOU CHOOSE TO WAIT ON YOUR PET AFTER DROP OFF, WE CAN NOT GUARANTEE WAIT TIMES.</i></b></p>				

Please circle one below.

How long has this been going on/when did it start.

**Drinking:** Increased      Decreased      No Change      \_\_\_\_\_

**Appetite:** Increased      Decreased      No Change      \_\_\_\_\_

**Defecation:** Increased      Decreased      No Change      \_\_\_\_\_

Please provide an image or best description of the enclosure. You can text images to 706-860-6617. Include temperatures and humidity as well as type of light and hours of light exposure for reptiles/amphibians.

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

What food (include all snacks, type, and amount of hay, treats) is your pet on? \_\_\_\_\_

Is your pet on any medications? Include all supplements please. (List frequency and route of administration: ex. Dusting vs. gut-loaded calcium vs. vitamin for reptiles) \_\_\_\_\_

Does your pet have any chronic health issues or previous surgeries? \_\_\_\_\_

If possible, today do you want any of the following done:

Nail/Beak Trim for bird (\$25+) \_\_\_\_\_ Wing clip (\$25+) \_\_\_\_\_ Nail Trim for exotic (\$16+) \_\_\_\_\_

**The examination is \$67      \*Current Patient Non-Scheduled Fee \$35 /New or Lapsed Patient \$50.**

What amount of money can be spent on diagnostics, treatments, etc. without further consent? (Please initial)

Exam fee+ \_\_\_\_\_ \$150-\$300      \_\_\_\_\_ \$300-\$600      \_\_\_\_\_ Unlimited      \_\_\_\_\_ Other - please specify (\$ \_\_\_\_\_ )

**Payment will be due in full when services are rendered & deposits will be asked for urgent care.**

Signature of Owner/Agent \_\_\_\_\_ Date \_\_\_\_\_

\*Name of Contact for the phone number listed below \_\_\_\_\_

Phone No. 1) \_\_\_\_\_ Alternate No. 2) \_\_\_\_\_