St. Francis Animal Hospital

Drop Off Treatment Form

Patient: ___________ Age: ______ Date _____

Owner_______________________________

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

Tech 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:	**This form is your primary communication to the doctor. Please fill it out according to your wishes, and note any concerns that need to be addressed today.** ***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. *** **PLEASE NOTE THAT IF YOU CHOOSE TO WAIT ON YOUR PET AFTER DROP OFF, WE CAN NOT GUARANTEE WAIT TIMES.**					

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 ____________________________
Urination: Increased Decreased No Change ____________________________
Defecation: Increased Decreased No Change ____________________________
Is your pet indoors or outdoors? ____________________
Is your pet current on vaccinations? ___________________ Date given? ____________ Clinic________________________

Is your pet on any medications? (list daily & monthly) ____
____

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

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

_____ Update Vaccines (w/Exam) _____ Nail Trim ($35) _______ Anal Gland Expression ($25) _____ Clean Ears ($22)

<u>M-F examination is $67. The examination with core vaccines included is $90. Additional Fee for Walk Ins-see below:</u>

<u>*Current Patient Non-Scheduled Fee $35 /New or Lapsed Patient $50*</u> For ADDITIONAL treatment please select an option below.

<u>Saturday the examination fee is $110. The examination with core vaccines included is $130</u>

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

Exam fee + _____$300, _____$300-$600, _____ Unlimited, _____ Other - please specify ($) [__] Call Prior to Treatments

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 2) __________________________________

Email ____________________________ TECH INITIALS: ____________