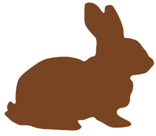
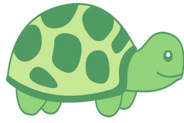
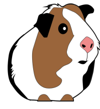
St. Francis Animal Hospital- EXOTICS FORM Patient Name: ____________________ Age: ______ Date: _____

Drop Off Treatment Owner's Name: ____

Email: 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:	**This form is your primary communication to the doctor. Please complete it thoroughly 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.** ***<u>For exotics, we prefer that you remain in the parking lot until a doctor has initially assessed your pet.</u>*** **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 ____________________________
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.

____
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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+) _______

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

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

Exam fee+ ______$300 ______ $300-$600 _____Unlimited _____ Other - please specify ($)

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) ____