



**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:</b> For Drop Off appointments we will call you as soon as we complete the exam to discuss treatment recommendations and discharge time.</p> <p><b><u>For exotics, we prefer that you remain in the parking lot until a doctor has initially assessed your pet.</u></b> PLEASE NOTE THAT IF YOU CHOOSE TO WAIT ON YOUR PET AFTER DROP OFF, WE CAN NOT GUARANTEE WAIT TIMES.</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 any and 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 \$65    \*Current Patient Non-Scheduled Fee \$25 /New or Lapsed Patient \$40.**

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** \_\_\_\_\_



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