



# Drop-Off Admission Form

Patient Name: \_\_\_\_\_

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

Preferred contact phone number: \_\_\_\_\_

Secondary contact name, in case you cannot be reached: \_\_\_\_\_

Secondary contact phone number: \_\_\_\_\_

## Medical History

What is your pet's diet and how much are they fed: \_\_\_\_\_

My pet's behavior is:      **Normal**       **Abnormal**  **Describe:** \_\_\_\_\_

My pet's stools are:      **Normal**       **Abnormal**  **Describe:** \_\_\_\_\_

My pet's urinary habits are:      **Normal**       **Abnormal**  **Describe:** \_\_\_\_\_

My pet's food intake is:      **Normal**       **Increased**       **Decreased**       **Last Ate:** \_\_\_\_\_

My pet's water intake is:      **Normal**       **Increased**       **Decreased**       **Last Drank:** \_\_\_\_\_

Does your pet take over the counter or prescription medications?      **Yes**       **No**

If yes, please list the medications: \_\_\_\_\_

\_\_\_\_\_

**Why are we seeing your pet today?**

**Wellness - Preventative Care (below)**

**Illness (pg. 2)**

### Wellness - Preventative Care:

Has your pet been sick in the past 7 days (vomiting, diarrhea, lethargy)?      **Yes**       **No**

If yes, please describe symptoms: \_\_\_\_\_

Annual/Bi-Annual Testing:      **All Due**       **Heartworm Test**       **Intestinal Parasite Screen**   
    **FeLeuk/FIV**       **Vaccine Titers**       **Annual/Bi-Annual Blood Work**

Canine Vaccines:      **All Due**       **Rabies**       **Distemper/Adenovirus/Parvovirus**       **Leptospirosis**   
    **Bordetella/Upper Respiratory**       **Influenza**

Feline Vaccines:      **All Due**       **Rabies**       **FVRCP - Respiratory**       **Leukemia**

Parasite Prevention:      **All Due**       **Flea & Tick**       **Heartworm**       **Intestinal Parasites**

Any other care, services, or medications needed for your pet's visit today?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Illness or Medical Concern:**

Date Illness or Medical Concern began: \_\_\_\_\_

Describe Illness or Medical Concern: \_\_\_\_\_

\_\_\_\_\_

Has your pet been vomiting? **No**  **Yes**   
How Long: \_\_\_\_\_ Color: \_\_\_\_\_ Substance: \_\_\_\_\_ Last Vomit: \_\_\_\_\_

Does your pet have access to food other than own pet food? **No**  **Yes**  What kind? \_\_\_\_\_

Has your pet been lame? **No**  **Yes**  Which limb(s): \_\_\_\_\_ How Long: \_\_\_\_\_

Injury details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Additional Authorizations**

During the day it is important that our hospital is able to reach the owner or person responsible for making decisions for the animal if anything occurs that is not planned or estimated.

Please choose **the best option below** to help us efficiently care for your pet in a timely manner.

**Please be aware during a life and death situation we will follow the signed Cardiopulmonary Resuscitation Form before calling for additional authorizations.**

Please choose **one option** to help us efficiently care for your pet in a timely manner.

- Please perform whatever medical procedures the Doctor deems necessary for the best possible care of my pet.
- I authorize up to  \$100.00,  \$250.00,  Other \$ \_\_\_\_\_, in additional procedures.
- Do Not perform any additional procedures, other than listed on this document, without specific authorization.

**Any pets staying in the hospital, for any reason, are required to be free of fleas, ticks, or any other external parasites. If the staff finds any parasites on your pet, we will administer parasite control at the owner's expense.**

**Initials** \_\_\_\_\_

I hereby authorize Advanced Care Veterinary Hospital and its staff to receive, prescribe for, vaccinate, and/or treat the animal listed on page 1, as needed for the health and well-being of the animal. Furthermore, I agree to pay for services rendered at the time the pet is discharged from the hospital.

Owner/Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_