

MEDICAL TREATMENT CONSENT FORM

Owner Name: _____ Animal Name: _____

- Yes No
 () () Did your pet eat this morning?
 () () Does your pet have a history of seizures?
 () () Is your pet allergic to any medications? If yes, list: _____
 () () Is your pet presently on medication(s)? If yes, list: _____

Please check the box that corresponds with the primary complaint(s):

Vomiting <input type="checkbox"/>	Diarrhea <input type="checkbox"/>	Blood in stool <input type="checkbox"/>
Coughing <input type="checkbox"/>	Sneezing <input type="checkbox"/>	Difficulty Breathing <input type="checkbox"/>
Frequent Urination <input type="checkbox"/>	Difficulty urinating <input type="checkbox"/>	Blood in the urine <input type="checkbox"/>
Painful <input type="checkbox"/>	Lethargic / depressed <input type="checkbox"/>	Not eating <input type="checkbox"/>
Losing weight <input type="checkbox"/>	Abnormal behavior <input type="checkbox"/>	Growth / Tumor <input type="checkbox"/>
Skin problems <input type="checkbox"/>	Ear problems <input type="checkbox"/>	Eye problems <input type="checkbox"/>
Other: _____		

Specify complaint(s): (i.e. left leg, growth on face, hiding, etc.) _____

Duration of condition(s) & current treatments: _____

MEDICAL STAFF TO FILL OUT - Diagnostics or Medical services planned

Physical Exam <input type="checkbox"/>	Vaccinations <input type="checkbox"/>	Bloodwork _____ <input type="checkbox"/>
Urinalysis <input type="checkbox"/>	Skin Scrape <input type="checkbox"/>	Heartworm/Lymes/EC Test <input type="checkbox"/>
Radiology <input type="checkbox"/>	Ultrasound <input type="checkbox"/>	FeLV/Fiv Test <input type="checkbox"/>
Fecal <input type="checkbox"/>	Eye stain / Treatment <input type="checkbox"/>	Thyroid Test <input type="checkbox"/>
Ear swab/stain/flush <input type="checkbox"/>	Other: _____	

Assisting Staff Member

Owner consent for diagnostics _____

I, as the owner or agent of the animal described above, am over 18 years old and have authority to exercise rights over this pet. I hereby authorize and direct the doctors and designated staff to perform the above-described procedure(s). The nature and purpose of the procedure(s) has been explained to me and I understand that no guarantee exists as to the result of diagnostics and/or treatments. Should any unforeseen conditions arise, the attending veterinarian may call for treatments other than those now being authorized.

If you would like a cost estimate for services that are planned, please ask the medical staff to prepare an estimate for you. All fees for services rendered are due upon discharge. These fees may include unforeseen circumstances not calculated in the estimate. If you have any questions or concerns regarding our policy, a staff member will be happy to address them prior to services.

Phone number(s) where you can be reached today: _____, _____

Signature (Owner/Agent): _____ Date: _____