WESTERN CAROLINA VETERINARY SURGERY

Referral Animal Hospital, P.A.

CLIENT INFORMATION **DATE** _____

Name: _____ **Spouse:** _____

Address: _____

City, State, Zip: _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email Address:** _____

(Permission to call work place ( ) Yes ( ) No

Drivers License No.: _____

Employer: _____

Employer Address: _____

Employer City, State, Zip: _____

REFERRING VETERINARIAN: _____

ADDRESS: _____ **PHONE:** _____

PATIENT INFORMATION **Pets Name** _____

Dog Cat (circle one) **Breed:** _____ **Color:** _____

Age: _____ **Birth Date:** _____ **Sex:** _____ **Spay Neuter (circle one)**

I authorize the examination of my pet, the administration of necessary treatments, and/or the execution of necessary diagnostic tests. I understand that an estimate of the charges will be given, and I assume full responsibility for all charges and concent to the release of medical information.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

PLEASE NOTE:

Due to high operating costs, the following policies have been established:

Full payment is expected when patient is released.

A 50% Deposit is required prior to surgery.

Accepted Payments: **Cash, Check, MC, Visa, American Express & Discover**

PATIENT INFORMATION *(Please Circle and / or fill in appropriate areas)*

How long have you owned your pet? _____

Diet... Can? Dry? Table food? Brand? Special? _____

Are there any other pets in your household? Yes ❑ No ❑ Describe: _____

Animal attitude: Gentle? Prefers women or men? Requires muzzle? Aggressive?

Does your pet have seizures? Yes ❑ No ❑ Name of medication _____

How long has your pet been sick or injured? _____ Days _____Months

Have there been any changes in your pet's normal activity? _____

Appetite Yes ❑ No ❑ Increased? Decreased? Describe: _____

Water intake Yes ❑ No ❑ Increased? Decreased? Describe: _____

Weight Increased? Decreased? Describe: _____

Urinations Increased? Decreased? Describe: _____

Bowel Habits Increased? Decreased? Straining? Diarrhea? Describe: _____

Vomiting Yes ❑ No ❑ Daily? Weekly? Intermittent? Describe: _____

Coughing Yes ❑ No ❑ Daily? Weekly? Intermittent? Describe: _____

Sneezing Yes ❑ No ❑ Daily? Weekly? Intermittent? Describe: _____

Skin Changes? _____ Itching? _____

Swellings or tumors Yes ❑ No ❑ Location? _____

Has your pet been taking aspirin? _____ Fish oil? If yes, which brand? _____

What medications is your pet taking now? (Includes herbal, supplements, over the counter) _____

_____

Is your pet on Heartworm Prevention? Name: _____

Is your pet current on vaccinations? _____

Any unusual reaction / allergy to medications? Yes ❑ No ❑ Describe: _____

List past medical problems (include surgery, trauma, etc.): _____

_____

_____

List the current medical / surgical problem(s) to initiate referral to WCVS: _____

_____

Do you have <u>any</u> veterinary information (i.e. referral letter) lab test results, x-rays, etc. for WCVS to review? Yes ❑ No ❑