Treatment Request Form:

Owner Name: ______________________ **Pet's Name**:____________________

Preferred method of contact:
Phone Call: ___________________ or Text Message: ________________

<u>If your pet has a flea infestation Capstar will be administered at time of arrival.**</u>**

Reason for today's visit:

___Physical Exam
___Vaccinations
___Heartworm/fecal test
___Surgery (*please sign anesthesia form*)
___Dental
___X-Ray
___ Follow up on previous exam/surgery
___Blood work
___Boarding: Pick up date:_______
___Bath
___Nail trim
___Flea treatment (**Specify which type below**)
___Other ____

___ Urinating more/less frequently/not at all
___Drinking more/less frequently
___Change in appetite, increase/decrease
___Weight loss/gain
___ Diarrhea /Constipation/Stool change
___Vomiting
___Runny eyes or nose
___Coughing or sneezing
___Itching or hair loss
___Lameness or Weakness
___Pain Where:_____________________

If any problem(s) checked above: When did it start?________________________________
Please describe in detail your pet's current symptoms and behavior:
____
____
____

Do you need any pet food, prescription refills, or heartworm, or flea prevention?
____

If during the exam, problems or conditions arise that require treatment that go beyond requested services, please indicate below how you wish us to proceed:

Please choose only <u>ONE</u> of the following options.

____ After examination, please perform all necessary diagnostic and treatment procedures Dr. Hale deems necessary.

____ After examination, please call me with an estimate of cost for recommended procedures or treatment. Please do not perform any procedures without my consent.

If there is any reason why full payment cannot be made at the time of pick up, prior arrangements must be made with the staff.

____ ___________________
SIGNATURE DATE