REQUEST FOR MEDICAL SERVICES

Please complete the following as thoroughly as possible so the doctor can accurately diagnose your pet's condition. We will call on the phone number below to discuss any questions or findings.

Owner's Name: _____ Date: _____

Phone Number (to be reached today):_____ Email: _____

Pet's Name:_____ Species: Dog ☐ Cat ☐ Other ☐

Reason(s) for medical exam: _____

_____

How long has the current medical problem occurred? _____

Is your pet currently on any medications for this problem? _____

_____

Have you noticed any of the following symptoms? (Please check all that apply & describe in detail below.)

Diarrhea ☐	Lethargy ☐	Swelling ☐
Vomiting ☐	Decreased Appetite ☐	Discharge ☐
Decreased/Increased Thirst ☐	Limping ☐	Discoloration ☐
Pain ☐	Coughing ☐	Sneezing ☐
Nasal Discharge ☐	Urinating/Defecating Problems ☐	Skin Problems ☐
Odor ☐	Ear Discharge/Odor ☐	Behavior Problems ☐

Need Products?

Flea/Tick ☐ Heartworm☐ Diet ☐

Additional Notes for the Doctor: _____

_____

_____

Would you like the following performed if due?

Fecal Test ☐ Heartworm Test ☐ Vaccinations ☐

Would you like to be informed of an estimate before diagnostics or treatment is performed? Yes ___ No ___

Only if exceeds $ _____

Owner's Consent

I authorize treatment, x-rays, or lab work if the doctor considers this necessary to diagnose the condition(s) above. Please type your initials here to authorize treatment.

_____