



Paros Veterinary Services

Small Animal Urgent Care

email completed form to:

urgentcare@parosveterinaryservices.com

360.219.1023

parosveterinaryservices.com

9222 Lundeen Rd. SW, Centralia, WA 98531

MEDICAL EXAM AND OWNER CONSENT FORM

CLIENT NAME: _____ PATIENT NAME: _____ DATE: _____

Species: CAT DOG OTHER BREED: _____

I authorize Paros Veterinary Services to examine my pet and/or provide the following services:
(no diagnostics, procedures, or therapy will be performed without first discussing options and costs)

- | | | |
|---------------------|-----------------|---------------------|
| SEDATION | RADIOGRAPHS | CATHETER AND FLUIDS |
| MEDICATIONS PER DVM | BLOODWORK | ULTRASOUND |
| VACCINATION | CYTOLOGY | BIOPSY/ASPIRATE |
| GENERAL ANESTHESIA | GENERAL SURGERY | OTHER |

I understand that there are inherit risks associated with anesthesia and surgical procedures, and I authorize the doctors & staff at Paros Veterinary Services to administer general anesthetic: injectable and/or inhalation. I will not hold Paros Veterinary Services LLC, the veterinarians, and staff liable for any complications that may arise

Please sign below by typing or signing your name/initials

MEDICAL HISTORY - Please describe the main reason for your visit.

Have you noted any **symptoms? (please note duration, frequency, and other details)**

Coughing	Sneezing	Describe: _____
Vomiting	Diarrhea	Describe: _____
Changes in Urination		Describe: _____
Changes in Eating/Drinking		Describe: _____
Change in Activity level		Describe: _____
Other symptoms or concerns: _____		

Please indicate all medications/supplements and monthly preventatives

RECORD OF TREATMENT

Pet's name	Species	Sex	Age
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