



# Spalding Animal Clinic Drop-Off Release

<b>Client:</b>	<b>Patient:</b>	<b>Sex:</b>
<b>Date:</b>	<b>DOB:</b>	<b>Species:</b>
<b>Phone:</b>	<b>Age:</b>	<b>Breed:</b>

Any Address Changes?

- Yes \_\_\_\_\_
- No

My pet is being dropped off for the following reason/treatment:

\_\_\_\_\_

Duration of problem: \_\_\_\_\_

Location of problem: \_\_\_\_\_

Is your pet currently on any medication? If yes, please write the name and the dosage of the medication.

- Yes \_\_\_\_\_
- No
- When was this medication last given? \_\_\_\_\_

<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Did your pet eat this morning?	<input type="checkbox"/>	<input type="checkbox"/>	Has your pet had any reaction to medications?
<input type="checkbox"/>	<input type="checkbox"/>	Was food offered?	<input type="checkbox"/>	<input type="checkbox"/>	Has your pet had any reaction to vaccinations?
<input type="checkbox"/>	<input type="checkbox"/>	<b>May we sedate/anesthetize?</b>	<input type="checkbox"/>	<input type="checkbox"/>	Has your pet had any reaction to anesthesia?

History: (mark any that apply, if yes how long/ often?)

- |  |   |
|--|---|
| <input type="checkbox"/> Shaking head? _____ | <input type="checkbox"/> Seizures? _____                          |
| <input type="checkbox"/> Vomiting? _____     | <input type="checkbox"/> Scooting? _____                          |
| <input type="checkbox"/> Diarrhea? _____     | <input type="checkbox"/> Urinating more or less than usual? _____ |
| <input type="checkbox"/> No Appetite? _____  | <input type="checkbox"/> Drinking more or less than usual? _____  |
| <input type="checkbox"/> Lethargic? _____    | <input type="checkbox"/> Limping? _____                           |
| <input type="checkbox"/> Weakness? _____     | <input type="checkbox"/> Which leg? _____                         |
| <input type="checkbox"/> Coughing? _____     | <input type="checkbox"/> Weight loss or gain? _____               |
| <input type="checkbox"/> Gagging? _____      | <input type="checkbox"/> Unusual lumps or bumps? _____            |
| <input type="checkbox"/> Scratching? _____   |   |

**Consent:** In the event of an emergency or if further diagnostics should be needed, we will make our best effort to reach you at the number provided at the top. However, should we be unable to reach you, please choose and initial one of the following:

- I **DO** authorize additional treatment without my consent
  - Up to \$ \_\_\_\_\_
  - Do whatever is needed
- I **DO NOT** authorize additional treatment of **ANY** kind without my consent.

I understand that, if I decline additional treatment, Spalding Animal Clinic cannot legally continue diagnostic or treatment other than already approved in person or by phone. If I do not select either option, Spalding Animal Clinic cannot legally continue with diagnostic(s) or treatment(s) of your pet.

\_\_\_\_\_  
Signature of owner or Authorized Agent

**Date:** \_\_\_\_\_