



1830 SE Princeton Drive, Suite A • Grimes, Iowa 50111
Phone: (515) 986-2841 • Fax: (515) 218-1733

Pet Drop-Off Information

Client name: _____

Telephone number where you can be reached: (_____) - _____ - _____

Pet's Name: _____ Breed: _____

Has your pet been seen by us before? YES ___ NO ___ (If not, please fill out a New Client form)

When was your pet's last meal (time and date): _____

What did he/she eat (type of food and quantity)? _____

What medications (if any) has your pet received in the last 24 hours?

Name of medication:	Amount given:	What time?

Is your pet sensitive or allergic to any medications or food? YES ___ NO ___ (If yes, please list below)

What vaccinations, if needed, would you like us to give your pet today?

- | | |
|--|--|
| <input type="checkbox"/> Rabies | <input type="checkbox"/> Leptospirosis (dogs only) |
| <input type="checkbox"/> Canine distemper (DA2PP) | <input type="checkbox"/> Lyme (dogs only) |
| <input type="checkbox"/> Feline distemper (FVRCP) | <input type="checkbox"/> Feline leukemia virus |
| <input type="checkbox"/> Bordetella (kennel cough) | |

Please describe the problem(s) your pet is having, pertinent history leading up to the current condition, any previous medical problems, and what you would like us to do below:

I would like you to:

- Treat and/or run any diagnostic tests on my pet after examination if the doctor deems it necessary.
- Call me with the physical examination findings and then quote me an estimate of treatment cost prior to treating my pet. (Please note that if we have not seen your pet before, we will need to be able to contact you regarding your pet's examination prior to instigating any treatments anyway.)
- Treat or run further diagnostic tests that the doctor deems necessary up to this amount: \$ _____

In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the veterinarian of Prairie View Animal Hospital and their support staff to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary. I also realize that all professional fees are to be paid at the time services are performed.

Signature: _____ Date: ____ / ____ / ____