AAHA ACCREDITED
The Standard of Veterinary Excellence

LAKESIDE ANIMAL HOSPITAL

Checked In By:_____

MEDICAL DROP-OFF FORM

Client (Owner):

Pet (Patient):

Drop Off Date: **Desired Pick Up Time:**_____

REASON:_____

_____

When did your pet last eat?_____

Please fill out the following to the best of your knowledge to better assist us:

Appetite:	□ Normal	□ Increased	□ Decreased
Drinking:	□ Normal	□ Increased	□ Decreased
Urination:	□ Normal	□ Increased	□ Decreased
Bowel Movements:	□ Normal	□ Other: _____	

Activity Level: □ Normal □Decreased(describe:)_____

Vomiting: □ No □ Yes

Current Medications (dosage, frequency, date/time last given):

_____

Refills needed? □ No □Yes:_____

Please **INITIAL** next to each item upon review:

_____I understand that if my pet is not free of external parasites such as fleas and or ticks, my pet will be treated appropriatley at my expense.

_____I understand that my pet must be immunized against rabies, distemper, bordetella and influenza in order to be hospitalized for any period of time at Lakeside Animal Hospital. Otherwise, my pet will be treated at my expense.

I HAVE READ THE FOREGOING, UNDERSTAND WHAT IS DESCRIBED, AND AGREE TO ALL TERMS.

Authorization Signature:_____ **Date:**_____

Name : Primary Phone No: (____)_____ Secondary Phone No : (____)_____