HARTLAND CAT HOSPITAL

Examinations and Drop-Off

Cats Name _____ Cats Age____ Owner_____
Phone#: _____ Email_____
Has your address changed? **If yes, please ask the front desk for a new address form!**
Reason for Exam:_____
Is your pet up to date on vaccines? ☐Yes ☐ No Date/Clinic given_____
Has your pet been seen by a previous vet? ☐Yes ☐No **If yes, please see the back of the form.**
Duration of Symptoms (if applicable)_____
Is the patient on flea/tick prevent? ☐ YES ☐NO Other Prevention:_____
Any known allergies?_____ FIV/FeLV Tested? ☐YES ☐NO
Is your pet currently micro-chipped? ☐Yes ☐No
Is it easier to give Pills? ___ or Liquid?_____
Is your pet currently on any medications/supplements? **If yes, please fill out the back side of the form.**

Please Select Appropriate Choice: Please fill out the form to completion each visit
Housing:☐ INDOOR ☐OUTDOOR ☐BOTH
How many cats are in the household?_____ How many dogs are in the household?_____
Appetite:☐NORMAL ☐DECREASED ☐INCREASED ☐NOT EATING How long? _____
H2O intake:☐NORMAL ☐DECREASED ☐INCREASED ☐NOT DRINKING How long? _____
Vomits:☐NEVER ☐OCCASIONALLY ☐FREQUENTLY How often and what? _____
BM:☐NORMAL ☐STRAINS ☐PAINFUL ☐HARD/DRY ☐BLOODY ☐DIARRHEA How often?_____

_____
Urinary: ☐NORMAL ☐STRAINS ☐PAINFUL ☐BLOOD ☐OUTSIDE LITTER BOX
Activity:☐NORMAL ☐VERY ☐ACTIVE ☐LETHARGIC ☐MORE ACTIVE ☐LESS ACTIVE
Respiratory:☐NORMAL ☐SNEEZING ☐COUGHING ☐DISCHARGE What color?_____
Parasite Control: All patients will be inspected for fleas at the time of admission. If fleas are present, a Capstar tablet will be given at the expense of the owner.

I give Authorization for the Following: Must select one or more
☐ Exam ☐Blood Work ☐ X-ray ☐ Sedation ☐Medication ☐UA ☐Vaccines
Please ask the technician for prices or an estimate if needed.

I hereby authorize the veterinarian to examine, prescribe for and treat the above pet. I assume responsibility for charges incurred in the care of this animal. I understand that these charges are due at the time services are rendered.
Signature _____ Date _____
Would you like to be called prior to extensive diagnostics **not checked above**?_____

Veterinary Tech:
Temp_____ Weight_____ Gained_____ Lost_____
Patient Behavior: BAR_____ QAR_____ Lethargic_____ Disoriented_____
Date of Last BW: _____
Results: _____

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Medication Name	What time was the last dose given?	What is the dosage?	How often is medication given?	If not prescribed by Hartland Cat Hospital, For what reason is it given and where was it prescribed.