*******2025********

Please Fill Out SECOND Page As Well

PETSRFAMILY ANIMAL CLINIC *NON-SURGICAL* DROP OFF FORM

Owner's Name: ______________________________________ Date: __________

Pet's Name: ___________________________________ Sex: ____ Spayed or Neutered: Yes/No

How far do you live from us? _______________________ (***ESTIMATED PICK UP TIMES VARY DEPENDING ON SEVERITY OF CASE AND LOAD)***

Primary Contact Number for Today: ____

Emergency Contact Number for Today: ____

Primary Complaints:

___ Vomiting ___ Itching ___ Painful ___ Diarrhea ___ Coughing ___ Hairloss

___ Growth/Lump ___ Blood in stool ___ Sneezing ___ Lethargic ___ Ears ___ Anorexia

___ Eyes ___ Difficulty Urinating ___ Lameness/Limping ___ Increased thirst

___Other: ____

Brief History for concern:

____

____

Pet's Medication and ALLERGIES?

____

Additional services requested today: (Please note some services may not be performed if pet is deemed too ill): ____

I authorize up to the following amount for treatment of my pet today: $__________

We will attempt to call with a treatment plan, if unable to reach we will proceed with treatment plan within designated amount. We will call and wait for response if needed services exceed the amount indicated. **Payment is due at time of service.** We accept Visa, Mastercard, Discover, American Express, Care Credit, Debit, Cash and Check.

I understand that PRFAH cannot be held accountable for the Loss/Damage to any belongings (covers/pillows/beds/leashes/collars) left with my pet.

PetsRFamily is open from 9am-7pm Monday-Friday and 9am-3pm on Saturday. Late pick up (10 minutes after closing) will incur a $65 'late pick up' fee due to holding staff over. If owner is no call/no show at 7pm the pet will be left in a kennel w/ food and water overnight where and $85 boarding fee will be incurred.

I authorize ____ to pick up my pet on my behalf.

Client Signature _______________________________________ **Date** ___________________

Sedation Consent Form

Patient Name: _______________ Breed: ___________ Sex: _______

Age: _______ Color: ______________

Authorization: In the event that _________________________ (pet's name) requires sedation during their visit today I _________________________ (owner's name) authorize sedation for my pet, as described above. ***I understand that that hospital staff will make every attempt to contact me in the event sedation is needed.*** The nature and risks of this procedure have been explained to me. ***I understand that there are always risks, including death, associated with sedation and anesthesia, and I am encouraged to discuss any concerns I have about those risks with the hospital's medical staff before the procedure is initiated.*** While PetsRFamily provides the highest quality of sedation/anesthetic monitoring, I completely understand the possibility of unforeseen complications that may occur during any associated anesthetic procedure and emergency care may be required for my pet – I have made the following (check box below) decision regarding emergency treatment. I fully acknowledge and understand these medical risks. I recognize that the veterinarians and hospital staff will do all that is necessary to minimize such risks. I will hold harmless PetsRFamily, the veterinarians, or any hospital staff member not liable for any complications that may or should arise in my pet's medical treatment and care. I understand that the hospital is not liable for any lost or damaged personal property (leashes, collars, etc.) that are left in the hospital.

MUST SELECT:

Pets Family's staff **has**___________ or **does not have**________ (initial one applicable phrase) my permission to provide any emergency treatment and/or treatment and care as the attending veterinarian or technician deems necessary.

________ I agree to pay for all related fees associated to such emergency care and/or treatment.

Signed: _________________________ Date: __________________________

Print: ____

OFFICE USE ONLY:		
RABIES ON FILE: YES OR NO	**ALL SIGNED: YES OR NO**	**INITAL:________**

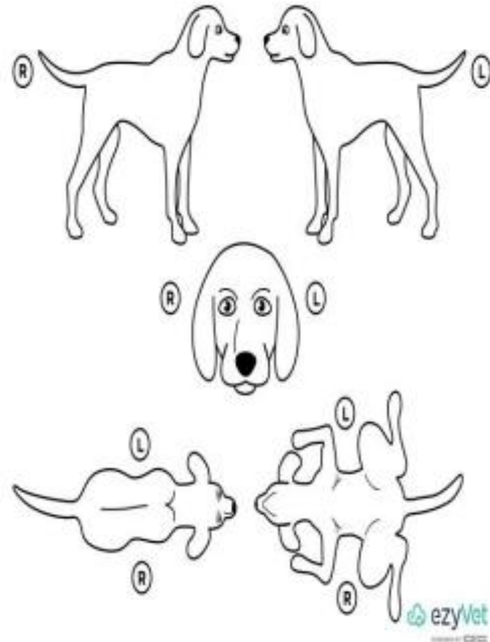
SOAP MEDICAL RECORD:

Name: ______________ **Today's Weight:** ____________ **Gender:** ______________

Age: ________________ **Previous Weight:** _____________ **TEMP.** ______________

SUBJECTIVE **_TECH:_** _________

1. **General Appearance** ☐ Healthy BCS ______ ☐ Dehydrated
2. **Attitude** ☐ BAR ☐ QAR ☐ Depressed ☐ Unable to examine
3. **Oral cavity** ☐ Normal ☐ Abnormal
   Tartar +1 +2 +3 Gingivitis +1 +2 +3
4. **MM** ☐ Normal ☐ Pale ☐ Jaundiced ☐ Tacky
5. **Eyes** ☐ Normal ☐ Abnormal
   Conjunctivitis Mild Moderate Severe OU OD OS
6. **Ears** ☐ Normal ☐ Abnormal AU AS AD
   Otitis Mild Moderate Severe
7. **Cardiovascular** ☐ Normal ☐ Abnormal ☐ Murmur
8. **Respiratory** ☐ Auscults normal ☐ Abnormal
9. **Abdomen** ☐ Palpates normal / non-painful ☐ Abnormal
10. **Neuro / Musculoskeletal** ☐ Normal ☐ Abnormal
11. **PLNs** ☐ Normal ☐ Abnormal
12. **Skin** ☐ Normal ☐ Abnormal



ASSESMENT:		***FOLLOW UP:***
TREAMENT PLAN:	***TECH :*** _______	***SUBQ FLUIDS:*** ***VITAMIN B INJ:*** ***CERENIA INJ:*** ***CONVENIA INJ:*** ***PEN. INJ:***