Pets R Family
Animal Hospital

***2026 NON-SURGICAL* DROP OFF FORM**

Owner's Name: _____ Date:_____

Pet's Name: _____

How far do you live from us? _____ Sex: ____ Spayed or Neutered: Yes/No

Primary Contact Number for Today (**CONTACT APPROVING TREATMENT PRICE TODAY)**:_____

Emergency Contact Number for Today: _____

A drop-off visit means you leave your pet with us for their examination and any necessary treatments. After the exam, we will contact you with a recommended treatment plan. This process may take a couple of hours, and while timing can vary based on case severity and clinic workload, your pet will be ready for pickup by 7pm.

Primary Complaints:

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

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

___ Difficulty Urinating ___ Lameness/Limping ___ Increased thirst ___Eyes _____Other

Brief History for concern (Duration of symptoms, etc)

_____

_____

Is your pet on any medication? If so, which?

_____

Does your pet have any 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. ***WE DO NOT ACCEPT CHECKS

Consent for Evaluation and Treatment of Self-Inflicted Trauma I, the undersigned pet owner, understand that my pet is exhibiting behaviors that may include self- inflicted trauma, specifically through repetitive chewing or biting of the cage bars. These behaviors have resulted in injuries such as trauma to the jaw, teeth, paws, nails, or even a fractured jaw. The veterinary staff will evaluate these injuries and may recommend treatment for the following:

- *Dental and Jaw Injuries: Including fractures, tooth damage, or other trauma due to excessive chewing.*
- *Paw and Nail Damage: Resulting from compulsive or repetitive behavior such as biting or chewing at the cage bars.*
- *Behavioral Assessment: To determine the underlying cause of the self-harming behavior, such as anxiety, stress, or compulsive tendencies.*

I understand and agree that Pets R Family Animal Hospital will not be held responsible for the self- inflicted injuries sustained by my pet as a result of its behavior. I acknowledge that these behaviors are outside the control of the clinic and that the hospital is not liable for the occurrence or progression of such injuries. I consent to the necessary diagnostic procedures, medical treatment, and behavioral consultations that the veterinary team deems appropriate for the health and well-being of my pet. I understand that the treatment plan may include behavioral modifications, medications, or other interventions to address the underlying causes of my pet's behavior, in addition to treatment for the physical injuries sustained.

***Client signature*_____**

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** _____

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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. (IF DEEMED NECESSARY BY DOCTOR)

Signed: _____ Date: _____

Print: _____

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

Pets Family Animal Hospital

SOAP - Sick Patient Form (OFFICE USE ONLY)

PATIENT INFORMATION:

NAME:_____ GENDER:_____ AGE:_____

CURRENT WEIGHT:_____ TEMPERATURE:_____ TECH FOR EXAM:_____

PREVIOUS WEIGHT_____ PATIENT ID:_____ TEMPERAMENT:_____

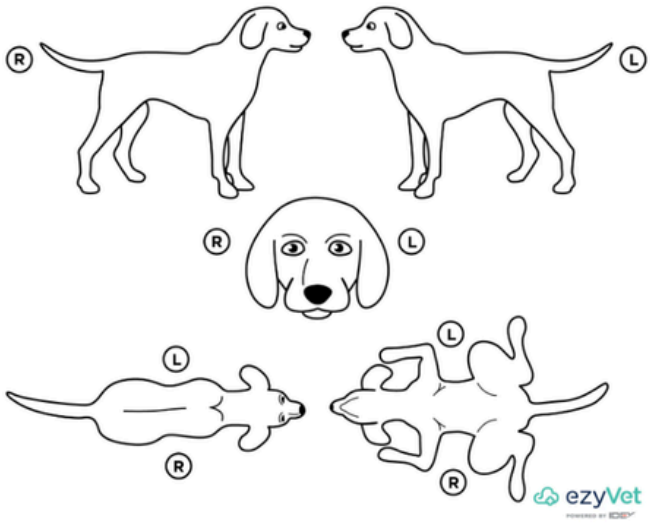
DOG/CAT

S- Subjective

PRESENTING CONCERN:_____

DURATION:_____

PROGRESSION: ☐ Better ☐ Worse ☐ Same



O- Objective

MM: ☐ Pink ☐ Pale ☐ Icteric ☐ Cyanotic

CRT:_____ seconds

Heart rate:_____ bpm

Pulse Quality: ☐ Normal ☐ Weak ☐ Bounding

Resp. Rate:_____ bpm

Effort: ☐ Normal ☐ Increased ☐ Labored

Auscultation

Heart: ☐ Normal ☐ Murmur (grade:_____) ☐ Arrythmia

Lungs: ☐ Clear ☐ Harsh ☐ Crackles ☐ Wheeze

Physical Exam

Hydration status: ☐ Normal ☐ Mild ☐ Moderate ☐ Severe Dehydration

Abdominal Palpation: ☐ Soft ☐ Painful ☐ Tense ☐ Mass

Musculoskeletal ☐ Normal ☐ Limping ☐ Painful ☐ Ataxia

Skin/Coat ☐ Normal ☐ Alopecia ☐ Lesions ☐ Masses ☐ Pruritus ☐ Wounds

Ears: ☐ Normal ☐ Debris ☐ Redness ☐ Pain ☐ Otitis Externa

Eyes ☐ Normal ☐ Discharge ☐ Redness ☐ Other:_____

Oral exam ☐ Normal ☐ Tartar ☐ Gingivitis ☐ Mass

Neurologic ☐ Normal ☐ Mentation change ☐ Seizure ☐ CN deficits

A- Assessment

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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P - Plan

Diagnostics:

☐ Ear Treatment	☐ Eye Treatment	☐ Skin treatment	☐ Xrays/Consult	☐ BW: _____
• Ear cleaning • Ear stain Cytology	• Eye stain • Eye tonometry	• DTM fungal • Skin scrape		

Symptomatic treatment:

- ☐ Subq Fluids : _____ mL
- ☐ Convenia _____ mL
- ☐ Cerenia_____ mL
- ☐ B12 _____ mL
- ☐ Cefazolin_____ mL
- ☐ Other_____

Additional treatments:

- ☐
- ☐
- ☐
- ☐
- ☐

Medications to go home

Results for IH treatment

- ☐ CALLED FOR TX PLAN
- ☐ APPROVED
- ☐ COMPLETE AND INVOICED: STAFF INITIAL____