1434 W. Alabama St.
Houston, TX 77006

Phone: 713-528-4900
Fax: 888-504-9006
www.MidtownVetHospital.com

Drop-Off : SICK PATIENT

Today's Date:

Contact Information

Owner's Name:

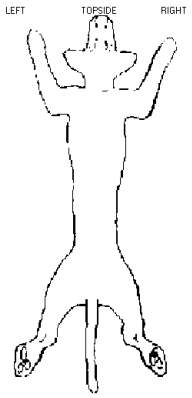
Phone Number to Reach You *Today*:

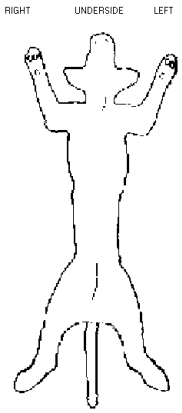
Additional Contact Information:

Pet Information

PETS NAME:

Has this pet visited our office before? ☐ Yes ☐ No





Reason For Today's Visit: SICK PATIENT EXAM

Please be as detailed as possible

Please check all that apply:

Vomiting first time:_____ last time:_____consistency: _____

Diarrhea first time:_____ last time_____ consistency:_____

Change in Appetite: ☐ Increased ☐ Decreased

Change in Urination: ☐ Increased ☐ Decreased ☐ Discoloration ☐ Straining ☐ Accidents in house

Change in Water Consumption: ☐ Increased ☐ Decreased

Change in Weight: ☐ Increased ☐ Decreased

Change in Attitude, please describe:

Excessive Scratching or Hair Loss, describe and indicate on diagram below:

Limping, which leg:

Lumps and Bumps, describe and mark on diagram below:

Poison Ingestion, type and time when ingestion occurred:

Seizure, frequency and severity:

Other:

ADDITIONAL SERVICES

YES	NO		YES	NO	
☐	☐	NAIL TRIM	☐	☐	EXPRESS ANAL GLANDS
☐	☐	MICROCHIP IMPLANT	☐	☐	SANITARY CLIP
☐	☐	CLEAN EARS	☐	☐	OTHER:

Authorization

After we examine your pet, how would you like us to proceed with treatment?

- ☐ Proceed immediately with treatment at Veterinarian's discretion
- ☐ Proceed with treatment, if the estimated cost is less than $ _____
- ☐ Call you with the findings of the examination and a cost estimate prior to initiating treatment

Deposits are required for all new accounts and for complicated procedures.
PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED.
In admitting my pet for diagnostics, treatment, or surgery, I authorize the veterinarians of Midtown Vet Hospital, and their support staff to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.

_____

Signature of Responsible Party

FOR TECHNICIAN USE ONLY:

AGE:
ATTITUDE:
BP/CUFF/LIMB:
CURRENT MEDS:
DIET (TYPE/FREQ):
HEART RATE:
PULSE:
RESP RATE:

TEMPERATURE:
CHANGE IN DIET?:
BOARD/DAYCARE?:
CURRENT MEDS:

OTHER NOTES: