



Blue Ravine Animal Hospital
1770 Prairie City Road
Folsom, CA 95630
(916) 984-0990

Drop-off Examination Request

Office use only:

Client ID #: _____

Pet weight: _____ Pet temperature: _____

Owner's name (First and Last): _____**Pet information:** Pet's Name: _____ Canine Feline Breed: _____ Male Female

The information requested will tell us the issues you would like to have addressed. It is important for you to be as specific as possible. If we need additional information, we will call you at the number you provide.

Thank you.

Phone Number(s): _____**Presenting Complaint:** _____

Please check all symptoms that apply to your pet:

- | | | | |
|---|---|---|-------------------------------------|
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Coughing | <input type="checkbox"/> Scratching |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Panting | <input type="checkbox"/> Limping |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Straining to urinate | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Increased urination | <input type="checkbox"/> Seizures | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Decreased energy | <input type="checkbox"/> Decreased urination | <input type="checkbox"/> Scooting | <input type="checkbox"/> Growths |
| <input type="checkbox"/> Other: _____ | | | |

Please describe in further detail the symptoms above, including location, if appropriate: _____

How long has your pet had these symptoms? _____

Has your pet been treated for the same condition in the past? _____

Can you associate this issue with a particular incident (e.g. injury, diet change, ingestion of foreign substance/toxin, etc.)? Please explain. _____

Is your pet on any medications? Please list and note time given: _____

Are there any other services that you would like to be performed (e.g. vaccines, heartworm test, prescription refill, etc.)? _____

Treatment / Testing Consent*

- After examination by the attending doctor, please proceed with tests and/or treatment.
- I would prefer a phone call prior to any additional tests/procedures.

*If your pet requires general anesthesia, we will give you an appropriate estimate and surgery release form prior to leaving your pet with us.

I, the undersigned, do hereby certify that I am the owner (duly authorized agent for the owner) of the animal described above, that I do hereby give Blue Ravine Animal Hospital's attending veterinarian and staff full and complete authority to address and treat the above issues as listed by myself. I certify that I have notified the doctor of any pre-existing conditions, such as seizures, allergic reactions, possible anesthetic complications, etc.

Signed (owner/agent): _____ **Dated:** _____