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:

☐ Vomiting  ☐ Weight loss  ☐ Coughing  ☐ Scratching
☐ Diarrhea  ☐ Weight gain  ☐ Panting  ☐ Limping
☐ Constipation  ☐ Straining to urinate  ☐ Difficulty breathing  ☐ Hair loss
☐ Decreased appetite  ☐ Increased urination  ☐ Seizures  ☐ Pain
☐ Decreased energy  ☐ Decreased urination  ☐ Scooting  ☐ Growths
☐ No concerns  ☐ 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 all necessary tests and/or treatment.

☐ After examination by the attending doctor ($53 exam fee), please proceed with the following minimal tests if deemed necessary by the doctor based on the presenting complaint:

☐ Inappropriate urination --- Urinalysis ($88)

☐ Squinting, eye pain, red eye, or eye discharge --- Fluorescein eye stain ($32), proparacaine ($20)

☐ Lameness --- Radiographs ($184+)

☐ Ear pain, redness, or discharge --- Ear cleaning and cytology ($47)

☐ Itchy skin, rash, hair loss --- Skin cytology ($49)

☐ Abscess, wound --- Wound clip and clean ($47), possible lidocaine injection ($40+), possible antibiotic injection ($45+)

☐ Diarrhea --- Fecal panel ($45), possible subcutaneous fluids ($42+), possible blood work ($66+)

☐ Vomiting --- Radiographs ($184+), injection for nausea ($42), possible blood work ($66+)

☐ Vomiting & diarrhea --- Radiographs ($184+), injection for nausea ($42), fecal panel ($45), blood work ($66+)

* If your pet requires treatment beyond the authorized minimum testing you have indicated, we will contact you to discuss further recommended diagnostics.

☐ 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: ___________________