

Rec/Tech Initials: \_\_\_\_\_



Blue Ravine Animal Hospital  
1770 Prairie City Rd  
Folsom, CA 95630  
916.984.0990

**Drop-off Examination Request**

**Client ID:**  
**Client Name:**

**Patient:**  
**Age:**  
**Species:**  
**Breed:**  
**Sex:**  
**Color:**

**Address:**

**Phone Number:**

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

**Phone Number(s):** \_\_\_\_\_

**Does your pet have any of the following symptoms:**

- |   |   |   |                                     |
|---|---|---|-------------------------------------|
| <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"/> No concerns        | <input type="checkbox"/> Other: _____         |   |                                     |

Please describe your pet's reason for visiting along with duration of symptoms, if any: \_\_\_\_\_

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

Is your pet on any medications or supplements? 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\*

I would prefer a phone call prior to any additional tests/procedures.

After examination by the attending doctor (\$70 exam fee), please proceed with the following minimal tests if deemed necessary by the doctor based on the presenting complaint (i.e., **I do not need a phone call to authorize the following**):

- Inappropriate urination --- urinalysis (\$135)
- Squinting, eye pain, red eye, or eye discharge --- fluorescein eye stain (\$39), proparacaine (\$25)
- Lameness --- radiographs (\$466 to \$611; up to three views)
- Ear pain, redness, or discharge --- ear cleaning and cytology (\$102)
- Itchy skin, rash, hair loss --- skin cytology (\$68)
- Wound --- clip/clean (\$89 to \$130) possible lidocaine injection (\$59), possible antibiotic injection (\$60+)
- Diarrhea --- fecal panel (\$70), possible subcutaneous fluids (\$80+), possible blood work (\$146 to \$169)
- Vomiting --- radiographs (\$466 to \$611; up to three views), injection for nausea (\$85), possible blood work (\$146+)
- Vomiting & diarrhea --- radiographs (\$466 to \$611; up to three views), injection for nausea (\$85), fecal panel (\$70), blood work (\$146 to \$169), spec cPL (\$72)

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

\*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.

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Client Signature	Date
Phone number(s):	

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