

# Drop Off Form

This information requested below tells us what you would like us to do for your pet. It is very important that you be specific so we can be certain to understand what you expect from our services. Please provide us with all of the current information in case we need to contact you. Thank you.

**Date:**

**Client ID:**

**Owner's Name:**

**Patient ID:**

**Pet's Name:**

**Breed:**

**Age:**

**Sex:**

**Please check the services below that you would like to have done today.**

## Vaccinations

## Tests & Services

Rabies 3Yr. (Dog/Cats over 1yr.)

Heartworm Test

Rabies 1Yr. (Dog/Cats over 12wks.)

Leukemia-Aids Test

Puppy 6wks. (No Lepto)

Diagnostic Blood Work

Puppy 10 or 14wks.

Deworm (Tapeworms)

Annual K-9 (DHALPP/Corona)

Deworm (Hook & Round)

Bordetella (Kennel Cough)\*K-9 only

X-Ray - Where?

Rattlesnake \*K-9 only

Bath

Annual Feline (FDC/FLV)

Bath & Dip

Kitten (FDC and Leukemia)

Nail Trim

Canine Flu Combo Initial

Express Anal Glands

Canine Flu Combo Annual

Microchip

Other: \_\_\_\_\_

Has your pet ever had a vaccine or drug reaction?                      Yes                      No

If Yes please explain: \_\_\_\_\_

If your pet is sick, please list the symptoms you have noticed. \_\_\_\_\_

How long have you noticed the symptoms listed above? \_\_\_\_\_

Please sign and date below to authorize the staff / staff veterinarians of Deason Animal Hospital, Inc. To perform the above mentioned services.

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

Day Time Phone Number Where You Can Be Reached: \_\_\_\_\_

Employee Checked-in: \_\_\_\_\_ Time: \_\_\_\_\_