Motherlode Veterinary Hospital Drop-Off Information
Consent For Treatment

Client Name : _____ Contact Number(s): _____
Patient Name : _____ _____
Date : _____

Though we prefer to be able to speak to you directly regarding your pets health, we understand that with certain circumstances a drop-off appointment may be necessary. Please fill out the following information to completion in order to help us best assess and care for your pet. The contact numbers listed above will be used for any additional information, follow-up, and notice of pick-up time. Please make sure you are available by phone in a timely manner so our staff can promptly obtain necessary information. If this is not possible please indicate a party in which you give consent to authorize treatment.

Reason for visit: _____
_____
When did the symptoms begin(please list any and all symptoms and observations)?
_____
_____
_____

Any signs of coughing, sneezing, vomiting, diarrhea? __ Yes __ No
If yes please indicate: _____
_____

Has your pet had any exposure to other animals (dog parks, boarding facilities, etc)
__Yes __ No

Has your pet been eating & drinking normally? __ Yes __ No
If you selected NO, for how long : _____

Has your pet eaten today? __ Yes __ No
If YES, at what time : _____

Is your pet currently on any medications? _____
When was the last time each medication was given? _____
_____
Does your pet have any allergies or sensitivities to medications? __ Yes __ No

If yes please indicate : _____

Is your pet on any flea/tick and/or heartworm prevention? __ Yes __ No

Are there any additional areas of concern you would like us to address today? If yes, please list all symptoms and observations: _____
_____
_____

Examination/Workup for your pet today may include x-rays, bloodwork, and/or sedation.
Are there any services to which you object? __ Yes __ No
If yes, to which services do you object : _____
_____

Following a complete exam and work-up would you like our office to contact you with an estimate before any treatment is started? __ Yes __ No

If treatment requires anesthesia do you give permission for your pet to be placed under anesthesia with observation by a technician/doctor and do you understand the risks associated with this procedure : Yes __ No __ N/A ___
I have additional questions relating to anesthetic procedures and request a call from the treating Doctor prior to anesthetic procedures : Yes ____ No ____

If we are unable to reach you, do you give permission to continue treatment?
__ Yes __ No
Up to what dollar amount do you authorize? _____

In case of an emergency, or in the case that you are unreachable, please indicate a persons you authorize to consent to treatment in your absence:
Name: _____ Phone : _____

I verify that I am 18 years of age or older and I hereby authorize the veterinarian to examine, treat and prescribe for the above described pet. I assume responsibility for all charges incurred in the treatment of this pet and understand that all charges are to be paid at the time of pickup.
Owner Signature: _____

All animals must be picked up before closing. Our office is open Mon-Fri 8am - 5:30pm unless otherwise indicated.

Please feel free to add any additional comments or concerns on the back of this page.