CASTRO VALLEY COMPANION
ANIMAL HOSPITAL
2509 Lessley Ave.
Castro Valley, CA 94546
510-582-6311
www.cvcah.com

Drop Off Consent Form

The information you provide below will let us know the best way to help your pet. It is important to be as accurate and as thorough as possible.

Owner's Name: _____ **Pet's Name:** _____

Phone number where you can be reached today: _____

***Emergency contact*:**

Name: _____ **Phone:** _____

What is the reason for today's visit? _____

Did your pet eat this morning? **Yes** ( ) **No** ( ) *If yes, what time?* _____

Is your pet sick? **Yes** ( ) **No** ( ) **Major Complaint:** _____

Has your pet been treated for this condition before? **Yes** ( ) **No** ( )

If yes, what date and where? _____

Current Diet: _____ **# of feedings:** _____ **Treat/Other foods:** _____

Is your pet currently on any medications? **Yes** ( ) **No** ( )
If yes, please fill out section below:

Medication: _____ **Dosage:** _____ **Frequency:** _____ **Last given:** _____
Medication: _____ **Dosage:** _____ **Frequency:** _____ **Last given:** _____
Medication: _____ **Dosage:** _____ **Frequency:** _____ **Last given:** _____
Medication: _____ **Dosage:** _____ **Frequency:** _____ **Last given:** _____

Is your pet on Heartworm Prevention? **Yes** ( ) **No** ( ) **Flea and Tick Prevention?** **Yes** ( ) **No** ( )

(If yes to any of the following, please circle all relevant words/phrases)

Change in appetite? **Yes ( )** **No ( )** **Not eating** **Decreased** **Treats only** **Eating more**

Diet change? **Yes ( )** **No ( )** *If so, when?* _____ **Days/Months Ago**

Change in drinking? **Yes ( )** **No ( )** **Drinking more** **Drinking less** **Not drinking at all**

Vomiting? **Yes ( )** **No ( )** *If so, for how many days?* _____

White **Yellow** **Pink** **Food** **History of Hairballs** **History of eating toys/string**

Diarrhea? **Yes ( )** **No ( )** *If so, for how many days?* _____

Watery **Blood tinged** **Mucous** **Dark/Tarry** **Soft**

Change in urination? **Yes ( )** **No ( )** **Bloody Urine** **Increased frequency** **Increased amount produced**

Urinating out of box **Smaller urine amounts** **More frequently** **Straining** **Vocalizing** **Accidents in home**

Coughing or Sneezing? **Yes ( )** **No ( )** **Moist** **Dry** **Honking** **Occurs at night** **Occurs during day** **Seasonal**

Lumps and Bumps? **Yes ( )** **No ( )** *(Please note on drawings where they are located)*

Right Underside Left Left Top side Right

Any additional information:

Additional Services Requested: *(Please circle)* **Heartworm Testing** **Acutherapy** **Ear Cleaning** **Nail Trim**

Vaccination Update **Fecal** **Microchipping** **Anal gland Expression**

I, the owner/agent, understand that by leaving my pet in hospital for treatment I am authorizing the attending veterinarian to examine my pet at the cost of $65.00 and that a hospitalization fee may or may not be charged depending on the circumstance. I understand that I will be charged for administration of a flea treatment if evidence of fleas is found during my pets hospital stay.

I, the owner/agent, understand the veterinarian will contact me after he/she has examined my pet to discuss recommended radiographs, diagnostics and treatments. I also understand that the veterinarian will be unable to proceed with any treatments until he/she has spoken directly with me and I have authorized this treatment and the charges associated with it.

I, the owner/agent, authorize the hospital staff and veterinarians, in an emergency situation, to perform any additional procedures necessary for the well-being of my pet until further communication with me or my emergency contact. I understand that payment is due at the time of discharge. I understand that follow-up examinations and additional treatments are not covered in today's costs. All patients entering the hospital must be current on all core vaccinations, unless here to receive today or is medically contraindicated.

Owner's Signature: _____ **Date:** _____

Witness Signature (Staff): _____ **Date:** _____