



864-585-5233

REQUEST FOR MEDICAL SERVICES

Please complete the following as thoroughly as possible so the doctor can accurately diagnose your pet's condition. We will call on the phone number below to discuss any questions or findings.

Owner's Name: _____ Date: _____

Phone Number (to be reached today): _____ Email: _____

Pet's Name: _____ Species: Dog Cat Other

Reason(s) for medical exam: _____

How long has the current medical problem occurred? _____

Is your pet currently on any medications for this problem? _____

Have you noticed any of the following symptoms? (Please check all that apply & describe in detail below.)

- | | | | |
|---|-----------------------------------|--|--|
| Diarrhea <input type="checkbox"/> | Vomiting <input type="checkbox"/> | Lethargy <input type="checkbox"/> | Swelling <input type="checkbox"/> |
| Decreased/Increased Thirst <input type="checkbox"/> | | Decreased Appetite <input type="checkbox"/> | Discharge <input type="checkbox"/> |
| Pain <input type="checkbox"/> | | Limping <input type="checkbox"/> | Discoloration <input type="checkbox"/> |
| Nasal Discharge <input type="checkbox"/> | | Coughing <input type="checkbox"/> | Sneezing <input type="checkbox"/> |
| Odor <input type="checkbox"/> | | Urinating/Defecating Problems <input type="checkbox"/> | Skin Problems <input type="checkbox"/> |
| | | Ear Discharge/Odor <input type="checkbox"/> | Behavior Problems <input type="checkbox"/> |

Need Products?

Flea/Tick Heartworm Diet

Additional Notes for the Doctor: _____

Would you like the following performed if due?

Fecal Test _____ Heartworm Test _____ Vaccinations _____

Would you like to be informed of an estimate before diagnostics or treatment is performed? Yes ___ No ___
Only if exceeds \$ _____

Owner's Signature

I authorize treatment, x-rays, or lab work if the doctor considers this necessary to diagnose the condition(s) above. Please type your initials here to authorize treatment. _____