



STIERN • SOUTHWEST • VETERINARY HOSPITALS

PATIENT DROP-OFF

Contact Phone Numbers Today: _____ Home Phone: _____

Owners Name: _____ Pets Name: _____

Reason for Examination:

1. _____
2. _____

If necessary for examination, do we have permission to sedate or anesthetize your pet?

Yes _____ No _____

When did you first notice the problem? _____

What has your pet been treated with at home? _____

How has your pet's appetite and water consumption been? _____

What has your pet eaten today and when? _____

Is your pet on any medication at this time? _____ Describe _____

Are there any other problems your pet might have of which we should be aware? _____

To effectively diagnose and treat many problems x-rays, blood tests and other procedures may need to be done. We will notify you before undertaking these tasks as to their need and cost. In the event of a life-threatening condition we will make every attempt to stabilize your pet and notify you as to the extent of the problem as soon as possible.

I HEREBY AUTHORIZE STIERN / SOUTHWEST VETERINARY HOSPITAL TO GIVE STANDARD AND ACCEPTED TREATMENT NECESSARY FOR THE WELL BEING OF MY PET, AND AGREE TO BE RESPONSIBLE FOR ANY AND ALL COSTS INCURRED IN CONNECTION WITH TREATMENT. I UNDERSTAND ONLY MINIMUM DIAGNOSTICS AND/OR TREATMENT WILL BE ADMINISTERED TO MY PET UNTIL WHICH TIME THAT I CAN BE CONTACTED FOR AUTHORIZATION.

Signature _____ Date _____