



St. Francis Animal Hospital

Drop Off Treatment Form

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Date \_\_\_\_\_

Owner \_\_\_\_\_

Phone: (706)860-6617 Email: [appts@sfah.net](mailto:appts@sfah.net)

Tech use: Weight \_\_\_\_\_ Temp \_\_\_\_\_

What will we be seeing your pet for today? \_\_\_\_\_

Primary Complaints (Circle All that apply):

Vomiting	Diarrhea	Blood in Stool	Blood in Urine	Inappropriate Urination	Difficulty Urinating	Increased Thirst
Anorexia	Lethargic	Hair loss	Itching	Sneezing	Difficulty Breathing	Coughing
Eyes	Ears	Painful	Lameness/Limping: Left Front	Right Front	Left Rear	Right Rear
Growth/Lump/Wound Location:	<p><b>This form is your primary communication to the doctor. Please fill it out according to your wishes, and note any concerns that need to be addressed today.</b></p> <p><b>*Drop Off Walk-Ins Only: For Drop Off appointments we will call you as soon as we complete the exam to discuss treatment recommendations and discharge time. *</b></p> <p><b>PLEASE NOTE THAT IF YOU CHOOSE TO WAIT ON YOUR PET AFTER DROP OFF, WE CAN NOT GUARANTEE WAIT TIMES.</b></p>					

Please circle one below.

How long has this been going on/when did it start.

**Drinking:** Increased    Decreased    No Change    \_\_\_\_\_

**Appetite:** Increased    Decreased    No Change    \_\_\_\_\_

**Urination:** Increased    Decreased    No Change    \_\_\_\_\_

**Defecation:** Increased    Decreased    No Change    \_\_\_\_\_

Is your pet indoors or outdoors? \_\_\_\_\_

Is your pet current on vaccinations? \_\_\_\_\_ Date given? \_\_\_\_\_ Clinic \_\_\_\_\_

Is your pet on any medications? (list daily & monthly) \_\_\_\_\_

Does your pet have any chronic health issues or previous surgeries? \_\_\_\_\_

If possible, today do you want any of the following done:

\_\_\_\_\_ Update Vaccines (w/Exam \$97)    \_\_\_\_\_ Nail Trim (\$35)    \_\_\_\_\_ Anal Gland Expression (\$27)    \_\_\_\_\_ Clean Ears (\$24)

**M-F examination is \$72. The examination with core vaccines included is \$97. Additional Fee for Walk Ins-see below:**

**\*Current Patient Non-Scheduled Fee \$38 /New or Lapsed Patient \$54\* For ADDITIONAL treatment please select an option below.**

**Saturday the examination fee is \$118. The examination with core vaccines included is \$140**

What amount of money can be spent on diagnostics, treatments, etc. without further consent? (please initial)

Exam fee + \_\_\_\_\_ \$300, \_\_\_\_\_ \$300-\$600, \_\_\_\_\_ Unlimited, \_\_\_\_\_ Other - please specify (\$) [ ] Call Prior to Treatments

**Payment will be due in full when services are rendered & deposits will be asked for urgent care.**

Signature of Owner/Agent \_\_\_\_\_ Date \_\_\_\_\_

\*Name of Contact for the phone number listed below \_\_\_\_\_

Phone No. 1) \_\_\_\_\_ Alternate 2) \_\_\_\_\_

Email \_\_\_\_\_ TECH INITIALS: \_\_\_\_\_