St. Francis Animal Hospital- EXOTICS FORM Patient Name: _____ Age: _____ Date: _____

Drop Off Treatment Owner's Name: _____

Email: appts@sfah.net Phone: 706-860-6617 **STAFF 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:		**This form is your primary communication to the doctor. Please complete it thoroughly and note any concerns that need to be addressed today.** ***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.** ***For exotics, we prefer that you remain in the parking lot until a doctor has initially assessed your pet.*** **PLEASE NOTE THAT IF YOU CHOOSE TO WAIT ON YOUR PET AFTER DROP OFF, WE CAN NOT GUARANTEE WAIT TIMES.**				

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 _____
Defecation: Increased Decreased No Change _____

Please provide an image or best description of the enclosure. You can text images to 706-860-6617. Include temperatures and humidity as well as type of light and hours of light exposure for reptiles/amphibians.

_____

_____

What food (include all snacks, type, and amount of hay, treats) is your pet on? _____

Is your pet on any medications? Include all supplements please. (List frequency and route of administration: ex. Dusting vs. gut-loaded calcium vs. vitamin for reptiles) _____

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

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

Nail/Beak Trim for bird ($30+) _____ Wing clip ($30+) _____ Nail Trim for exotic ($20+) _____

The examination is $72 ***Current Patient Non-Scheduled Fee $38 /New or Lapsed Patient $54.**

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

Exam fee+ _____$300 _____ $300-$600 _____Unlimited _____ Other - please specify ($)

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 No. 2) _____