

**St. Francis Animal Hospital- EXOTICS****Drop Off Treatment**Email: appts@sfaah.net Phone: 706-860-6617

Patient Name: _____ Age: _____ Date: _____

Owner's Name: _____

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: | <p>This form is your primary communication to the doctor. Please complete it thoroughly and note any concerns that need to be addressed today.</p> <p>*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.</p> <p><u>For exotics, we prefer that you remain in the parking lot until a doctor has initially assessed your pet.</u> PLEASE NOTE THAT IF YOU CHOOSE TO WAIT ON YOUR PET AFTER DROP OFF, WE CAN NOT GUARANTEE WAIT TIMES.</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 _____
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:

Wing & Nail Trim (\$55) _____ Wing clip (\$35) _____ Nail Trim for exotic (\$23) _____

The examination is \$80 ***Current Patient Non-Scheduled Fee \$43 /New or Lapsed Patient \$60.**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) _____