F-Series/VaccineClinicExistingPatientFelineTrialRun/11/2021

NORTHWEST ANIMAL CLINIC & HOSPITAL

STAFF VERIFY VACCINES ( )

To the best of my knowledge this information is correct ( )

Important medical information

Date ___/___/___ Initial

The Reason for this visit:_____

Has this patient experienced any of the following: Please **Circle** yes or no.

yes no -- Gaining weight or Losing weight ? (circle one)

yes no -- Limping

yes no -- Seizures

yes no -- Ear problems

yes no -- Fainting or weakness

yes no -- Coughing, sneezing, wheezing (circle all that apply)

yes no -- Urination changes/difficulties

yes no -- Increased or Decreased appetite (circle one)

yes no -- Vomiting

yes no -- Spayed/Neutered Year_____

yes no -- Scratching

yes no -- Depressed /listless

yes no -- Eye problems

yes no -- Lumps or bumps

yes no -- Increased water consumption

yes no -- Bad breath

yes no -- Other? _____

Stools are : normal or abnormal (circle one)

Diet consists of _____

Patient's Lifestyle (Indoor/Outdoor) _____

Current medications:_____

CONSENT FORM: Read and Sign Below.

I am the owner, or the agent of the owner, of the above described animal and have the authority to execute this consent. I hereby consent and authorize the performance of the listed procedure or operation. I understand that during the performance of the procedure or operation, unforeseen conditions may be revealed that necessitates extension of the listed procedure, or operation, of different procedure(s) or operation(s) than those set forth.Therefore I hereby consent to and authorize the performance of such procedure(s) or operation(s) as are necessary and desirable in the exercise of the veterinarian's professional judgment. I also authorize the use of appropriate anesthetics and other medications and I understand that hospital support personnel will be employed as deemed necessary by the veterinarians to provide the necessary care for this animal..

I have been advised as to the nature of the procedure or operation and the risks involved including death. I realize that results cannot be guaranteed.

Payment is due at time of service. $____Cash ____Credit Card ____Check _____Care Credit

I have read and understand this authorization and consent to the listed procedure(s).

Signature:_____ Date:_____ Phone #:_____

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Vaccine Clinic Services Felines

Please **Circle** the following services that you would like for your pet today:

(Prices Plus Tax)

Rabies **Yes No** ($7.00)

a deadly neurological disease contagious and fatal to humans

FVRCP **Yes No** ($22.00)

Panleukpenia (P). Infection that causes bloody diarrhea and can be fatal
Rhinovirus (R). Infection that causes respiratory disease
Calicivirus (C). Infection that causes respiratory disease

FELV **Yes No** ($27.00)

Acts like human AIDS viruses

Would you like to schedule an Annual Physical Exam? Yes No ($55.47)

Dispense Flea Products Yes No (Varies)

Notes:

Patient:_____ Date:_____