Client ID:
Inputted by:
office use only

GLADES PIKE VETERINARY HOSPITAL

Feline Wellness Drop- off Exam Questionnaire

Owner's Name	
Pet's Name	
Date	
Pick- up time	

**Pick- up times are not guaranteed*

What does your pet need done today?

☐ Exam ☐ Vaccines ☐ Other:_____

Please check the WELLNESS check up items you would like completed today

☐ Fecal test
☐ Annual Bloodwork
☐ Nail Trim
☐ Vaccines
☐ FIV/ FELV test
☐ Flea and Tick Prevention
☐ Heartworm Prevention
☐ Other:_____

Please select the vaccines for which your pet is currently due:

☐ Core vaccination: FVRCP
☐ Rabies
☐ Feline Leukemia (must have FIV/ FELV test)

Please select your choices for Flea, Tick, and Heartworm preventives:
**select only one*

Revolution Plus (MONTHLY Flea/Tick/ Heartworm prevention)

☐ Single dose ☐ 6 month supply ☐ 12 month supply

Bravecto (8 week Flea/Tick/ Heartworm Prevention)

☐ Single dose ☐ 6 month supply ☐ 12 month supply

Paradefense (Monthly Flea Prevention):

☐ Single dose ☐ 6 month supply ☐ 12 month supply

Is your pet currently receiving any medications? If yes, Please list medications and dose below

Medication	Dose

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Please list any other comments or questions for the doctor:

It is VERY important that the doctor is able to reach you if we have questions regarding your pet. Failure to be reached may result in postponement of your treatment.

Primary number:_____
Alternate number:_____

☐ ***PLEASE initial so that we know you have read this statement: We REQUIRE PROOF of Rabies for ALL appointments. PLEASE bring proof of rabies vaccination with you. If this is not provided, we will vaccinate your animal for Rabies***

We would GREATLY appreciate it if you are able to provide us access to your pet's previous medical records.

Drop- off exams are offered for your convenience. Your pet will be examined as the doctor's schedule allows. Critical patients will be examined and stabilized immediately. Pick up times cannot be guaranteed.

I, the owner of the pet above, authorize Glades Pike Veterinary Hospital to examine, diagnose, and treat my pet as described above. I accept full responsibility for all costs incurred. I understand that, as a condition of treatment by this hospital, all payments must be made at time of service. In the event that this account should go unpaid, I will be subject to the costs of collections, including attorney fees and/or collection agency fees.

Pet Parent Signature: **Date:**