COMPANION
ANIMAL HOSPITAL, SPRINGFIELD VA
Companions for life

Surgery/ Dental /Anesthesia Drop-Off Form

Today's Date: _____

Owner: _____

Pet's Name: _____

Primary reason for visit:

_____

Additional services (vaccinations, etc)?

_____

● Has your pet had any of the following symptoms? Please circle all that apply.

Vomiting	Weight loss/gain	Coughing
Diarrhea	Lethargy	Decreased appetite
Constipation	Limping	Increased Appetite
Blood in stool	Tumor/mass	Pain

Bad Breath

Increased drinking/urination Scratching/Skin Problems

Other: _____

7927 Commerce St. Springfield, VA 22150
P: (703)866-4100 F: (703)866-4926
www.companionanimalhospitalva.com

● Is your pet on any medications? If so, what are they and when were they last given? _____

● Is your dog on monthly heartworm preventative? YES NO

What brand?_____ **Refill?** **YES** **NO**

● Is your dog/cat on monthly flea & tick control? YES NO

What brand?_____ **Refill?** **YES** **NO**

● Has your pet had any food today? YES NO

What time? _____

● Do we have your permission to administer anesthetics or sedatives necessary for certain procedures?

YES NO

● If any dental care will be performed, do you pre-approve any extractions that the doctor feels are necessary?

YES NO

VERY IMPORTANT

Please leave a number where you may be reached should the doctor need to speak with you. Important decisions may need to be made while your pet is with us today.

Phone Number(s):

_____

I give permission for my pet to be treated as described above:

Owner's Signature: _____

CAH Employee's Initials: _____

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