F-Series/VaccineClinicExistingPatientFeline/8/2018

NORTHWEST ANIMAL CLINIC & HOSPITAL

STAFF VERIFY VACCINES

To the best of my knowledge this information is correct
Date ___/___/___ Initial

***Important medical information***

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 #:_____

NORTHWEST ANIMAL CLINIC & HOSPITAL

# 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*

Intestinal Parasite Assessment **Yes No** ($35.12)

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

Dental Checkup FREE Yes No (Free)

Dispense Flea Products Yes No (Varies)

Notes:

Patient:_____ Date:_____