

CROSSROADS ANIMAL HOSPITAL
651 HWY 71 W
BASTROP, TX 78602
512-321-0506



PHIL FARBER, DVM
JOEY HALLEY, DVM

PLACE PATIENT LABEL HERE

FELINE TREATMENT DROP OFF FORM

PLEASE GIVE US IMPORTANT INFORMATION ABOUT YOUR PET

Noticed Fleas: YES NO **Noticed Ticks** YES NO
On Flea/Tick Prevention: NO YES Date given _____ Every Month ?
On Heartworm Prevention: NO YES Date given _____ Every Month ?
Has Tested Positive For: Feline Leukemia Virus FIV (Feline AIDS Virus)
Date of last Feline Combo Test (if not done here): _____ POS NEG
Other Cats?: YES NO **FELV POS** YES NO **FIV POS** YES NO
Habitat: Indoor Only Indoor/Outdoor Outside Only
Foods: Brands: _____ Dry Wet
 Eats Specific Meals Free Choice Table Food, What % _____
Water Consumption: Normal Increased Decreased
Activity Level: Very Active Normal Very Inactive
Behavior: Any Noticeable changes? _____
Lameness: Which Legs R/F L/F R/R L/R Date Started _____
 Constant Intermittent
Difficulty Rising: YES NO If YES for how long _____
 None Occasionally Frequent / Frequency? _____
What? Food Phlegm Yellow Bile Hair ball
Constant Relationship to Eating? YES NO
Diarrhea: None Occasionally Frequent / Frequency? _____
of BM per day _____ Straining? YES NO Blood Mucous
Coughing: None Occasionally Pet Frequently with other K9/FEL? YES NO
Sneezing: None Occasionally Frequent
Nasal Discharge: NO YES Puss Watery Bloody Started _____
Itching: None Seasonal Year-Round Itching Where? _____
History of Fight Wounds: NO YES How Many in Last 2 Years? _____
Growth: YES NO **Please see back of form for further detail.**
Additional Info: (use back too) _____

FEL Special	<input type="checkbox"/> w/ DR.	<input type="checkbox"/> w/ Tech			Anal Glands	<input type="checkbox"/> YES	Check Ears	<input type="checkbox"/> YES
FVRCP	<input type="checkbox"/> Annual	<input type="checkbox"/> #1	<input type="checkbox"/> #2	<input type="checkbox"/> #3	Nail Trim	<input type="checkbox"/> YES	S/R(suture)	<input type="checkbox"/> YES
FELV	<input type="checkbox"/> Annual	<input type="checkbox"/> #1	<input type="checkbox"/> #2		Microchip	<input type="checkbox"/> YES	Fecal	<input type="checkbox"/> YES
Rabies	<input type="checkbox"/> YES				Deworm	<input type="checkbox"/> YES		
Combo Test	<input type="checkbox"/> YES				Full Bath	<input type="checkbox"/> YES	Sedate OK	<input type="checkbox"/> YES
Senior Wellness: (evaluation of liver, kidneys & pancreas, etc from blood test)								<input type="checkbox"/> YES

We cannot guarantee all pets coming in will be free of fleas. If your Pet is found to have fleas upon arrival they will be given a single dose of Capstar without consent, at your expense

Staff Initials: _____

Date: _____

Check-In Time: _____

DROP OFF POLICY

Please note: there is no guaranteed pick up time for drop offs, regardless of the time your pet was dropped off. All animals are assessed at time of entry and monitored until one of our Doctors can complete a treatment plan. **If you need an estimate prior to any treatment please check here:** []. Once a treatment plan has been accepted and administered the Technical Staff will call with updates and/or a ready to go time.

If a Pet is not picked up prior to closing once a ready to go has been given, there will be an overnight boarding charge added at the Owners' expense. (M-F 6:00 pm, Sat 1:00 pm)

Payment is due in full at the time of pickup.

Some procedures may require partial payment prior to services. We do not offer payment plans, but we can assist you in applying for Care Credit. We also accept all major credit cards and cash.

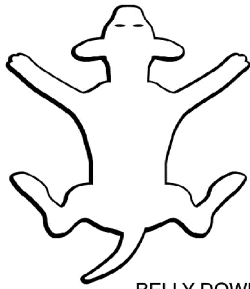
How would you like to be contacted? [] Phone [] Text

Your signature acknowledges you have read and understood the above policies.

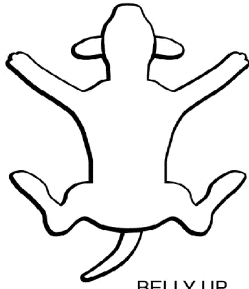
X _____ Phone # _____

GROWTH/LESION CHART

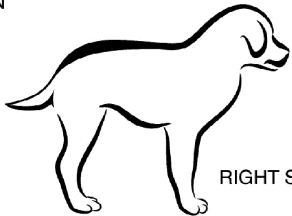
GROWTH/LESION CHART:
Please map on the chart(s) below any growths, masses or lesions you would like checked and or removed today. Please leave specific instructions on length of time noticed, if its gotten bigger/color change, etc. Also, note if you would like removed, aspirated or both. Please also leave good, valid phone numbers so the Doctor can reach you if possible. Thank you :)



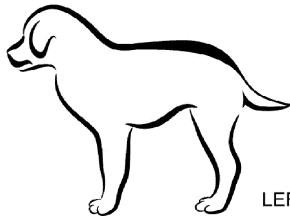
BELLY DOWN



BELLY UP



RIGHT SIDE



LEFT SIDE

Additional information regarding growth (or other concerns regarding Pet's health)

Thank you for entrusting us with your pet's care. We will do everything we can to honor that trust and provide your pet with the best care possible.

Crossroads Animal Hospital

Staff Initials: _____

Date: _____

Check-In Time: _____