PATIENT DROP OFF FORM

Owner ______________________________________ Patient: __________________________________

Brief history of problem: ____

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Date issue was first noticed: ____

Current medications/supplements: ____

I authorize the following tests and/or treatments the Doctor recommends:

- ☐ Physical Exam ($63)
- ☐ Toe Nail Trim ($23)
- ☐ Anal Gland Expression ($35)
- ☐ Ear Cleaning ($30)
- ☐ Radiographs ____
- ☐ Blood Tests ____
- ☐ Other Laboratory Tests ____
- ☐ Injections ____
- ☐ Vaccines ____

I require prior authorization if total cost exceeds $ ______________________.

I understand that oral medications and topical treatments are not quoted in the above checklist because they are subject to the Doctor's discretion and dosing.

I understand that the patient must be picked up by 5:45 pm or additional boarding charges will apply.

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Signature of Owner/Responsible Agent Date

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Phone Number and/or Emergency Contact

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Signature of Admitting Hospital Staff