
**PO BOX 309 5610 BARRETT AVENUE, FERNDALE WA. (360) 384 - 0212**

# DROP OFF TREATMENT REQUEST

Date: _____Name: _____ Pet's Name: _____
Your pet will be seen by the FIRST available veterinarian for their current condition, unless you request a specific doctor, if available: _____
Since you will not be present during the exam, please provide the doctor with a specific explanation of their current condition. By providing as much information as possible, the doctor will be better equipped to diagnose and treat the problem. Use the back of this paper if needed.

Duration of problem? When was the last time your pet ate?

Is your pet currently on any medication or receiving any treatment of any kind?

Is this a recurring problem? If yes, how frequent, and has your pet been treated for this problem by another veterinarian?

If the doctor were unable to reach you today, what further treatment, if any, would you authorize?

Exam _____ Blood/Urine Tests _____
Sedation/Anesthesia _____ Whatever Necessary _____
X-rays _____ Other _____

Call me if my total will be over: (**circle one**) $100 $150 $200 Other $ _____
**Payment is required at time of service,** please circle your preferred payment method:

CASH CHECK CREDIT CARD (VISA, MASTERCARD, DISCOVER)

**Please leave all phone numbers where you may be reached today**

_____
____

Signature _____

Your pet will need to be picked up by 5 PM today unless other arrangements have been made with the doctor/hospital staff.