Westridge Pet Hospital & Wellness Center
6695 Tri County Parkway
Schertz, TX 78154
(210) 651-4236

Drop-off Examination Request

Owner's name (First and Last):_____
Pet information: Pet's Name:_____

The information requested will tell us the issues you would like to have addressed. It is important for you to be as specific as possible. If we need additional information, we will call you at the number you provide.
Thank you.
Phone Number(s):_____
Presenting Complaint:_____
_____

Please check all symptoms that apply to your pet:

☐Vomiting	☐Weight loss	☐Coughing	☐Scratching
☐Diarrhea	☐Weight gain	☐Panting	☐Limping
☐Constipation	☐Straining to urinate	☐Difficulty breathing	☐Hair loss
☐Decreased appetite	☐Increased urination	☐Seizures	☐Pain
☐Decreased energy	☐Decreased urination	☐Scooting	☐Growths

☐Other:_____
Please describe in further detail the symptoms above, including location, if appropriate:_____
_____

How long has your pet had these symptoms?_____

Has your pet been treated for the same condition in the past?_____

Can you associate this issue with a particular incident (e.g. injury, diet change, ingestion of foreign substance/toxin, etc.)? Please explain._____
_____
_____

Is your pet on any medications? Please list and note time given:_____
_____

Are there any other services that you would like to be performed (e.g. vaccines, heartworm test, prescription refill, etc.)?_____
_____

Treatment / Testing Consent*
☐After examination by the attending doctor, please proceed with tests and/or treatment up to $175 in cost.
☐I would prefer a phone call prior to any additional tests/procedures.

*If your pet requires general anesthesia, we will give you an appropriate estimate and surgery release form prior to leaving your pet with us.

I, the undersigned, do hereby certify that I am the owner (duly authorized agent for the owner) of the animal described above; that I do hereby give Westridge Pet Hospital's attending veterinarian and staff full and complete authority to address and treat the above issues as listed by myself. I certify that I have notified the doctor of any pre-existing conditions, such as seizures, allergic reactions, possible anesthetic complications, etc.

Signed (owner/agent):_____ **Dated:**_____