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 www.golflinksvet.ca reception@golflinksvet.ca

Pet Drop-off Admission Form

Owner: _____ Date: _____

Pet: _____

REASON FOR EXAMINATION: Briefly describe the nature of the problem.

How long has this been occurring? _____

Is the condition: Worse? Better? Staying the same?

Are you presently giving any medications? (If yes then list) _____

What food are you feeding? _____

PLEASE CHECK APPROPRIATE DESCRIPTION OF THE FOLLOWING:

Attitude	<input type="checkbox"/> Normal	<input type="checkbox"/> Lethargic		
Appetite	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	
Drinking	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	
Urinating	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Straining	<input type="checkbox"/> Blood
Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N	How long?	# times a day	<input type="checkbox"/> Blood
	Colour		Associated with eating? <input type="checkbox"/> Y <input type="checkbox"/> N	
Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	How long?	# times a day	<input type="checkbox"/> Blood
	Colour		Straining to have a bowel movement? <input type="checkbox"/> Y <input type="checkbox"/> N	
Coughing	<input type="checkbox"/> Y <input type="checkbox"/> N	How long?	Worse: <input type="checkbox"/> at night <input type="checkbox"/> during day <input type="checkbox"/> after exercise	

After your pet is examined by the veterinarian we will contact you regarding test results and further diagnostics/ treatments needed. If you have not been contacted by 12:00 pm for morning admissions or by 4:00 pm for afternoon admissions, please call us at the hospital at (905) 304 PETS(7387).

Contact Number: (_____) _____ Ideal time: _____

Owner's signature: _____