SUWANEE ANIMAL HOSPITAL

85 Buford Highway
Suwanee, GA 30024
(770) 271-8716
FAX (770) 271-1944
www.suwaneeanimalhospital.com

Hours:
Monday-Thursday 6:30 am-8 pm
Friday 6:30 am-6 pm
Saturday 8 am-4 pm
Closed Sundays/Major Holidays

ABSENTEE EXAM ADMITTANCE FORM

CLIENT: _____ **PET:** _____ **dog / cat** (circle)

DROP OFF DATE*: _____ **PET CARE PLAN MEMBER?** □ yes □ no

*please make a note of our regular business hours when arranging pick up

DOCTOR PREFERENCE: (circle one)

Dr. Margaret Fitzgerald Dr. Joe Fitzgerald Dr. Tony Watson Dr. Madeline Lowery

Dr. Anita Patel Dr. Henry Pan Dr. Jeremiah Rusiewicz Dr. Carlie Beach No Preference

MEDICAL INFORMATION Rcpt. Init. _____

1. List any medications your pet is currently taking: _____
2. List any medications your pet is allergic to: _____
3. Has your pet ever had a reaction to a vaccine? □ yes □ no (If yes, we may need to pre-treat with an antihistamine injection)
4. Please list any previously diagnosed medical conditions: _____
5. Please check off your pet's current symptoms and explain:

□ Vomiting □ Lack of Appetite □ Lameness □ Skin Problem □ Eye Problem □ Diarrhea □ Lethargy □ Scratching
□ Sneezing □ Difficult Urination □ Constipation □ Tumor/Growth □ Ear Problem □ Other □ Requires Vaccines

Explain: _____

_____

5. Number of days problem has persisted: _____
6. Date and time of most recent meal (include type/brand): _____
7. Date/time of last bowel movement: _____ Normal? □ yes □ no
8. Date/time of last urination: _____ Normal? □ yes □ no

BATHING AND GROOMING

We offer bathing and grooming while your pet is our guest, saving you time and effort.

□ **Nail trim** $20.00 □ **Express Anal Glands** $27.00
□ **Bath** (nail trim, anal gland expression, brush out- price based on weight) $27-42.00
□ **Medicated Bath** (for dry, oily or itchy skin) $15 □ **Cream Rinse** (for soft and shiny coat) $8
□ **De-matting** (remove mats, brush out hair) $21
□ **Mini-Groom** (face, feet, tail, ears, trouble areas) bath + $34
□ **Sanitary Clip** (trouble areas) $25
□ **Additional Walks** $7

Notice: if your pet is bathed, please pick up after 4 pm (11 am Saturdays). Please call ahead if you need early pick up.

GENERAL WELLNESS PROCEDURES

Most general wellness procedures are included at no charge for pets enrolled in our Pet Care Plan.

□ **Blood Profile** (for internal organ function)
□ **Urinalysis**
□ **Chest X-ray**
□ **Thyroid Screening**
□ **Blood Pressure Screening**
□ **Feline Heartworm Screening**
□ **De-worming** (roundworm/hookworm)
□ **EKG**
□ **Dental Cleaning** (requires sedation)
□ **Microchip**

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Would you like a quote only for the services you selected? □ yes □ no

PHARMACY

1. **Heartworm Preventative Refill:** (circle one) 1 month 6 months 12 months Other: _____
2. **Flea Control Refill:** (circle one) 1 month 6 months 12 months Other: _____
   Notice: Any pet with fleas will be treated immediately with a single dose of Capstar, Advantage or Frontline at your expense.
3. **List any other prescriptions you would like refilled including prescription diet dog or cat food:**

_____

_____

VACCINATIONS

Please indicate which of the recommended vaccines/tests you authorize us to administer (*denotes required vaccines). If your pet is current on the required vaccines, you must provide records from the other clinic. If your pet was last vaccinated with us, we will let you know what vaccines are required.

CANINE

□ ***Rabies** (circle one: 1 yr. 3 yr.)
□ ***DHPP or DHLPP** (yearly after booster after series & 1-yr. booster)
□ ***Kennel Cough** (every 6 months)
□ **Fecal Parasite Test** (every 6 months)
□ **Heartworm Test** (yearly unless missed doses Of preventative)
□ ***Canine Influenza H3N8**

FELINE

□ ***Rabies** (Purevax is 1 yr.)
□ ***FVRCP** (circle one: yearly after booster series 3 yr. 3 yr. after series & 1-yr. booster
□ **Fecal Parasite Test** (every 6 months)
□ **Feline Leukemia Purevax** (1-yr. vaccine)
□ **Feline Leukemia/FIV test** (if at risk)

CLIENT APPROVAL

Initials

Sedation
In the event that radiographs or a procedure requires sedation to allow proper positioning, examination or treatment, we request that you initial above. *Note: sedation usually costs $69-115

Please Select One:

Initials

□ I authorize whatever tests/treatments the doctor feels are necessary.
□ I authorize whatever tests/treatments the doctor feels are necessary, but call first if estimate greater than $_____
□ I would like the doctor to call me before any tests or treatments are performed (*please make sure you can be reached at the contact number: _____)

Signed: _____ Date: _____ Emergency Phone #: _____