



For office use only:
 Dr. _____
 TOA: _____
 Appt. Time: _____
 Date: _____
 Weight: _____

ONCOLOGY PATIENT DROP OFF / RECHECK FORM

Patient: _____ **Species:** _____ **Breed:** _____

Sex: _____ **Age:** _____ **Previous Weight:** _____ **Pt. ID #:** _____

Person dropping off patient: _____

Telephone # where you can be reached: _____

Which best describes your pet's health since last visit? Excellent Good Fair Poor

Please describe any problems since last visit (vomiting, diarrhea, lethargy, loss of appetite, etc.), When did problem occur? Did it resolve?

List any questions or concerns that you would like to discuss with your doctor:

What medications have you given your pet since the last visit & do you need any refills?

Name of Medication	Dose (mg or # of pills)	How often given	# of days	Need refill?

I, the undersigned, owner of admitted patient, hereby authorize Upstate Veterinary Specialists to administer such treatment as is necessary and are considered therapeutically necessary on the basis of findings during the course of the evaluation. I also consent to the administration of such anesthetics as are necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. Furthermore, I assume all financial responsibility for charges incurred to the patient, consent to release of medical information, and authorize direct payment to Upstate Veterinary Specialists. I understand that I am liable for all collection costs, up to 100%, incurred for this account.

Client Signature: _____ **Date:** _____