SOUTHERN HILLS
ANIMAL HOSPITAL

Treatment Authorization Form

Please complete the following information and email to recep1@sohillsvet.com OR Fax to 318.686.2011.

Pet's Name:_________________________________ **Your Name**:_______________________________

Please Describe Reason for Drop Off / Main Concern:____

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I understand that by leaving my pet, I will incur an "Office Visit" Charge of $51.50. I also agree to treatment costs; up to: ❑$100 ❑$150 ❑$200 ❑$250 ❑$300 (__________ Initial)

Your veterinarian will contact you for any associated costs above $300.00

URINE: ❑Clear ❑Cloudy ❑Dark ❑Bloody Other:__________________________

FECES: ❑Soft ❑Diarrhea ❑Dark ❑Bloody Other:__________________________

VOMITING: ❑Yes ❑No ❑Clear ❑Foamy ❑Food Other:__________________________

Current Medications:____

____

Heartworm Prevention (Current? ❑Yes ❑No); Medication:_______________________

Flea/Tick Prevention (Current? ❑Yes ❑No); Medication:__________________________

Current Diet:____

My pet is: ❑Inside ONLY ❑Outside ONLY ❑Both

In order for the doctor(s) to get a complete diagnosis of your pet's condition, it may be necessary to complete the following diagnostic procedures. Please mark EACH of the following that you AGREE to which will allow the doctor to perform. Selecting any of these procedures below does NOT mean said procedures will automatically be completed or needed.

❑Bloodwork ❑X-Rays ❑Sedation ❑IV Catheter/Fluids

I understand that humane measures will be performed at the doctor's discretion. I give permission for treatment as requested and/or recommended including any necessary protection for my pet's safety.

Signature:____ Date____________________

Your Primary Contact #:____