



Chemotherapy Drop Off Form

PET OWNER FORM

Your pet is here for chemotherapy treatment. To help us provide optimal care for your pet, please take a few moments to answer the following questions.

OWNER NAME: First: _____ Last: _____ Mr. Mrs.
PET'S NAME: _____ Ms. Dr.

1 For today's visit, does your pet require any medications or special food while in clinic? Yes No

If YES, please specify:

Drug name: _____ Dose: _____ Time: _____

Drug name: _____ Dose: _____ Time: _____

Food: _____ Time: _____

2 Has your pet visited their family veterinarian since we last saw you? Yes No

If YES, why? _____

a) Were any of the following performed? Blood work Urine X-rays

b) List name and dose of medications dispensed:

Drug name: _____ Dose: _____ Time: _____

Drug name: _____ Dose: _____ Time: _____

3 Do you require any refills on your pet's medications? Yes No

If YES, which medication(s)? _____

4 Since your pet's last visit, please comment on the following: (check boxes as appropriate)

a) **Appetite:** No change Increased Decreased Duration of change: _____

b) **Drinking:** No change Increased Decreased Severity of change: _____

c) **Urination:** No change Increased Decreased Severity of change: _____

d) **Vomiting:** Yes No Approximate # of times: _____

How many days after treatment: _____

e) **Diarrhea:** Yes No Approximate # of times: _____

How many days after treatment: _____

f) **Quality of life:** Unchanged Improved Decreased

g) **Overall attitude / energy level:** Excellent Good Fair Poor

Comments: _____

5 Please list any additional questions / concerns that you have:

6 I authorize the following to be performed:

No testing without consultation Blood work Chest X-rays

X-rays of the following body location(s): _____

Ultrasound Needle biopsy of lymph nodes/masses

Urinalysis Urine culture Other testing deemed necessary

Comments: _____

7 BEST contact name and phone number for TODAY's visit (REQUIRED): _____

Alternative name and phone number: _____

8 Authorization (REQUIRED)

I (Client / Agent's Name) _____

Authorize CWVS to perform chemotherapy on (Pet's name) _____

Signed: _____ **Date:** _____

*Thank you for your time.
CWVS Oncology Service*