T: 604-473-4882
F: 604-473-4898
referrals@canadawestvets.com

CANADA WEST
VETERINARY SPECIALISTS

PET OWNER FORM

1988 Kootenay Street
Vancouver, BC V5M 4Y3
canadawestvets.com

Neurology Consultation Questionnaire

PLEASE PRINT CLEARLY. This information is for hospital communication purposes only.

OWNER NAME: First: _____ **Last:** _____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

PET'S NAME: _____

PATIENT INFORMATION

☐ **Dog** ☐ **Cat** ☐ **Other** **Breed:** _____

Age (DOB): _____ **Sex:** ☐ M ☐ F ☐ Spayed ☐ Neutered ☐ Intact **Colour:** _____

Do you have insurance for this pet? ☐ Yes ☐ No **If so, please indicate:** ☐ PetSecure ☐ Trupanion ☐ PetCare

Origin: ☐ Breeder ☐ Store ☐ Shelter ☐ Other (Please provide name, location and date below):

_____ Date: _____

OWNER / PRIMARY CONTACT

Address: _____ **Unit #:** _____

City: _____ **Province/State:** _____ **Postal Code:** _____

Home#: _____ **Cell#:** _____ **Work#:** _____

Email: _____ (so we can email you reports or information)

ADDITIONAL OWNER / CONTACT

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. **First:** _____ **Last:** _____

Does this person also have the decision-making authority? ☐ Yes ☐ No

Home#: _____ **Cell#:** _____ **Work#:** _____

Email: _____ **Relation to above:** _____

FAMILY VET INFORMATION

Your regular veterinary hospital: _____

Your veterinarian's name: _____

Have you been to our hospital before? ☐ Yes ☐ No ☐ Unknown. **If so, with which pet?** _____

Professional fees are due at the time services are rendered. Surgery and hospitalization will require a deposit at the time of admittance. We accept cash, debit, Mastercard, VISA and AMEX. We do not accept personal or business cheques.

CONTINUED ▶▶

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Please provide only a one or two word answer OR just tick the appropriate box.

1. **When was he or she last normal?** _____
2. **What was the first sign that you noted?** _____
3. **Has your pet had any known exposure to bats?** ☐ Yes ☐ No
4. **Rabies vaccine current?** ☐ Yes ☐ No
5. **Any travel to Vancouver Island or outside of BC?** ☐ Yes ☐ No

   If YES, please specify: _____
6. **Has your pet had any diarrhea or vomiting in the last month?** ☐ Yes ☐ No
7. **Has your pet had any coughing or sneezing in the last month?** ☐ Yes ☐ No
8. **Has your pet shown any compulsive circling?** ☐ Yes ☐ No
9. **Has your pet shown any compulsive pacing?** ☐ Yes ☐ No
10. **Has your pet shown any change in behaviour?** ☐ Yes ☐ No
11. **Has your pet shown any change in temperament?** ☐ Yes ☐ No
12. **Has your pet had trouble recognizing someone familiar?** ☐ Yes ☐ No
13. **Has your pet started urinating in inappropriate places?** ☐ Yes ☐ No
14. **Has your pet started defecating in inappropriate places?** ☐ Yes ☐ No
15. **Has your pet been staring vacantly at the walls?** ☐ Yes ☐ No
16. **Has your pet been pressing his or her head into a corner?** ☐ Yes ☐ No
17. **Has your pet been bumping into things as if they could not see?** ☐ Yes ☐ No
18. **Has your pet had any seizures?** ☐ Yes ☐ No
19. **Has your pet had any collapsing episodes?** ☐ Yes ☐ No
20. **Has your pet had any loss of balance?** ☐ Yes ☐ No
21. **Is your pet taking any medications at the moment?** ☐ Yes ☐ No
22. **Is your pet eating and drinking normally?** ☐ Yes ☐ No
23. **Has your pet had any other major illnesses or injuries?** ☐ Yes ☐ No

    If YES, please specify: _____
24. **How old was your pet when you first acquired him or her?** _____
25. **Has your pet recently received aspirin (acetylsalicylic acid)?** ☐ Yes ☐ No

    If YES, please specify the dose and time received: _____
26. **Do you have any other comments?**