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Oncology Recheck Form

PET OWNER FORM

Your pet is here for a recheck appointment. 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. ☐ Ms. ☐ Dr.

PET'S NAME:_____

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:_____

Please describe circumstances:_____

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

Please describe circumstances:_____

f) **Lameness / joint soreness:** ☐ Yes ☐ No

Please describe circumstances:_____

g) **Neurologic abnormalities (loss of balance, seizures):** ☐ Yes ☐ No

Please describe circumstances:_____

h) **Respiratory abnormalities (cough, nasal discharge, rapid breathing etc.)** ☐ Yes ☐ No

Please describe circumstances:_____

i) **Quality of life:** ☐ Unchanged ☐ Improved ☐ Decreased

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

Comments:_____

Please indicate any additional questions / concerns that you have:

5 **Fasted** ☐ Yes ☐ No **Time of last meal:**_____

6 **I authorize the following to be performed:**

☐ No testing without consultation ☐ Blood work ☐ Urinalysis

☐ Urine culture ☐ Ultrasound ☐ Chest X-rays

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

☐ Other testing deemed necessary ☐ Needle biopsy of lymph nodes/masses

☐ Sedation ☐ General anesthesia

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: ☐ Melanoma VX ☐ Chest Rads ☐ Other:

on (Pet's name)_____

Signed:_____ **Date:**_____

Thank you for your time.
CWVS Oncology Service