TIME: _____

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

CANADA WEST
VETERINARY SPECIALISTS

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

Patient/Owner Information Form

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

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

PET'S NAME: _____

OWNER / PRIMARY CONTACT

Address: _____ **Unit #:** _____

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

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

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

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 YES, please indicate: ☐ Trupanion ☐ Petsecure/Petline ☐ PetsPlusUs ☐ 24 Petwatch ☐ Fetch/Petplan

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

_____ Date: _____

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 YES, 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.

If your pet is here for OUTPATIENT RADIOLOGY, stop here. **For all other services, please complete pages 2 and 3.** ▶▶

PATIENT: _____

CURRENT DIET

☐ Free choice ☐ Set meals per day

Brand name: _____ Amount/meal: _____ Canned ☐ Dry ☐ # Meals/day: _____

Brand name: _____ Amount/meal: _____ Canned ☐ Dry ☐ # Meals/day: _____

Any known food allergies/intolerance? ☐ Yes ☐ No

If YES, please indicate known allergies or allergen testing done:

VACCINE HISTORY

Last vaccine given: _____ Date: _____

Has an up-to-date rabies vaccine? ☐ Yes ☐ No

TRAVEL HISTORY

Please indicate location, approximate date and length of visit:

DRUG REACTIONS

Please indicate any known adverse reactions/allergies to vaccines, oral medications, anesthetics and/or topical drugs or shampoos:

CURRENT MEDICATION

Please list all medications including topical medications, flea prevention and herbal/vitamin supplements:

Medication	Dosage	Frequency

Do you have any other pets at home? ☐ Yes ☐ No

If YES, has your other pet(s) been diagnosed with any types of illness recently? ☐ Yes ☐ No

MEDICAL HISTORY

Have you noticed any of the following in your pet (please check appropriate boxes):

1. ☐ **Change in water intake.** If YES, have you noticed an ☐ increase or ☐ decrease
   Total water intake: _____ cups/day ☐ Measured ☐ Approximate

2. ☐ **Change in urination.** If YES, have you noticed any ☐ straining ☐ blood
   Frequency: _____ times per day

3. ☐ **Vomiting.** If YES, please describe (i.e. bile/undigested food/blood) and include frequency:

4. ☐ **Diarrhea.** If YES, have you noticed any ☐ blood ☐ mucous
   Frequency and consistency: _____

5. ☐ **Change in appetite.** 6. ☐ **Change in body weight.**

Has your pet exhibited any other symptoms? ☐ Yes ☐ No. **If YES, please describe behaviour changes:**

Has your pet recently had an X-ray? ☐ Yes ☐ No. **If YES, how long ago?**

Please list any previous medical problems:

Date	Condition