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## PET OWNER FORM

1988 Kootenay Street  
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# Surgery Consultation Questionnaire

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

OWNER NAME: First: \_\_\_\_\_ Last: \_\_\_\_\_ ☐ Mr. ☐ Mrs.  
PET'S NAME: \_\_\_\_\_ ☐ Ms. ☐ Dr.

## 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.

## PATIENT INTAKE FORM

What condition are you bringing your pet in for?

How long has this condition been present? (Please list the date if known)

Has the condition been:      worsening ☐      improving ☐      staying the same ☐

If your pet is limping, which limb(s) are affected:      Left front ☐      Right front ☐  
   Left rear ☐      Right rear ☐

Has your pet received any non-medication treatments for this condition?      ☐ Yes      ☐ No

If YES, please describe:

Please list all current medications that your pet is taking (including flea/tick preventatives and herbal/vitamin supplements), as well as any previous medications used to treat the presenting condition.


Has your pet had any adverse reactions to any medications?      ☐ Yes      ☐ No

If YES, please describe:

**Has your pet recently experienced any of the following?**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| • Vomiting   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Diarrhea   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Change in appetite                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Change in body weight                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Change in drinking                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Change in urination (frequency, straining, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**If you answered yes to any of the above, please describe:**

**Has your pet exhibited any other abnormal symptoms?**

☐ Yes

☐ No

If YES, please describe:

**Please list any previous medical conditions that your pet has been diagnosed with.**

**Has your pet had any recent bloodwork?**

☐ Yes

☐ No

**Has your pet had any recent x-rays taken?**

☐ Yes

☐ No

**What diet are you currently feeding your pet?** Please include type and frequency.

**Does your pet have any food allergies?**

☐ Yes

☐ No

If yes, please list what your pet is allergic to.

**Is your pet up to date on vaccines?**

☐ Yes

☐ No

**Is your pet:** indoor only ☐ outdoor only ☐ or indoor/outdoor ☐

**Has your pet travelled outside of the province?**

☐ Yes

☐ No

If yes, please list the location, approximate date and length of visit.