MEDICAL TREATMENT CONSENT FORM

Fleur Pet Hospital
4524 Fleur Dr
Des Moines IA 50321

Owner: _____

If owner is not present, person dropping off patient: _____

Phone Number: _____ Alternate Number: _____

Patient: _____

Primary Complaint(s): Please check the ones that apply:

Vomiting ☐ Diarrhea ☐ Blood in stool ☐ Coughing ☐ Sneezing ☐ Pain ☐
Difficulty Breathing ☐ Lameness or Limping ☐ Not eating ☐ Not drinking ☐
Urinating frequently or in odd places ☐ Blood in urine ☐ Unable to urinate ☐
Weight loss ☐ Itching ☐ Lethargic or depressed ☐ Increased thrist ☐
Check a growth ☐ Ear problem ☐ Eye problem ☐

Other:_____

Specify Complaint(s): (left leg, growth on face, hiding etc..) _____

_____

Duration of the condition (hours, days or weeks) and any current medications that have been given for the condition: _____

_____

Any medications given today: _____

For anticipated services, please refer to the estimate that has been figured for you. If there are more services that need to be done, Dr. Williams will be calling to give an update of your pets' condition and her recommendations that may go beyond the initial treatment plan.

I am the owner or the agent of the animal described above.

I have authority to execute this consent and am over the age of 18.

The nature and purpose of the procedure(s) has been explained to me and I understand that no guarantee exists as to the result of diagnoses and treatment of said animal.

I have had the fees outlined to me and agree to pay all such fees and charges at the time of discharge.

I have read and understand this consent.

_____ _____

Signature of owner or agent Date