65 Buford Highway
Suwanee, GA 30024
(770) 271-8716
FAX (770) 271-1944
www.suwaneeanimalhospital.com

Hours:
Monday-Thursday 6:30 am-8 pm
Friday 6:30 am-6 pm
Saturday 8 am-4 pm
Closed Sundays/Major Holidays

ABSENTEE EXAM ADMITTANCE FORM

CLIENT NAME: ___________________________ **PET NAME:** ____________________ **dog / cat** (circle)

DROP OFF DATE*: ______________

DOCTOR PREFERENCE: (circle one)

Dr. Ashiana Thacker Dr. Carlie Beach Dr. Fabiola Flores-Reyero Dr. Morgan O'Brien Dr. Henry Pan

Dr. Jeremiah Rusiewicz Dr. Tony Watson **NO PREFERENCE**

MEDICAL INFORMATION

1. Please explain your pet's current symptoms: ____
2. List any medications your pet is currently taking: ____
3. List any medications your pet is allergic to: ____
4. Has your pet ever had a reaction to a vaccine? □ yes □ no (We may need to pre-treat with an antihistamine injection)
5. Please list any previously diagnosed medical conditions: _____________________________________

VACCINATIONS

Indicate which of the vaccines/tests you authorize us to administer (<u>*denotes required vaccines for all drop offs</u>). If your pet is normally seen elsewhere you must provide records at drop off or via email: frontdesk@suwaneeanimalhospital.com

CANINE - Initial next to approved vaccines

_____ □ ***Rabies** (circle one: 1 yr. 3 yr.)
_____ □ ***DHPP or DHLPP** (circle one: 1 yr. 3 yr.)
_____ □ ***Kennel Cough**
_____ □ ***Fecal Parasite Test (**every 6 months)
_____ □ **Heartworm Test**
_____ □ **Canine Influenza H3N8/H3N2**

FELINE - Initial next to approved vaccines

_____ □ ***Rabies** (Purevax is 1 yr.)
_____ □ ***FVRCP** (circle one: 1 yr 3 yr)
_____ □ ***Fecal Parasite Test (**every 6 months)
_____ □ **Feline Leukemia Purevax** (1-yr. vaccine)
_____ □ **Feline Leukemia/FIV test** (if at risk)
_____ □ **Wellness BW**

PHARMACY REFILL

1. **Heartworm Preventative Product Name:** ________________ **Amount:** (circle one) 1 month 6 months 12 months
2. **Flea Control Product Name:** ________________________ **Amount:** (circle one) 1 month 6 months 12 months

   Notice: Any pet with fleas will be treated immediately with a single dose of Capstar, Advantage, or Frontline at your expense.
3. **List any other prescriptions you would like refilled including prescription diet dog or cat food:**

____

CLIENT EXAM APPROVAL

By signing below you acknowledge and accept the exam charge and above vaccinations & tests needed. If the doctor has any questions, concerns, additional findings, or recommended tests or treatments you will be contacted.

Signed: ____________________________ Date: __________ Emergency Phone #: __________________

EMERGENCY CARE

<u>Initial one option below:</u>

________ I **<u>DO</u>** grant SAH permission to provide necessary medical treatment at my own expense if I cannot be reached.

________ I **<u>DO NOT</u>** grant **SAH** permission to provide emergency care and wish my pet declared **DNR.**

Revised 9/20/24