



**VETERINARY
EMERGENCY
CLINIC**

Client & Patient Information Sheet

To be filled out by clinic staff

Client Data

Last Name: _____ First Name: _____

Please select one: Mr. Mrs. Ms Miss Dr.

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone #'s: Home: _____ Cell: _____ Work: _____

Referring Veterinarian: _____

Clinic Name: _____

Are you sending radiographs with client? Yes No

Are you faxing lab data? Yes No

Patient Data

Pet's Name: _____ Species: Canine Feline

Breed: _____ Male Female

Neutered/Spayed? Yes No Colour: _____

Date of Birth: _____ or Approximate age: _____

Are vaccines current? Yes No

Pet Insurance? Yes No Company: _____

Does the pet have any history of seizuring and or drug reactions? _____

