MEDICAL NEEDS ASSESSMENT

YOUR NAME: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP _____

PHONE: _____ ALT PHONE: _____

RELATION TO PET: □ OWNER □ FOSTER □ VETERINARIAN □ OTHER _____

PETS NAME: _____ BREED: _____ WEIGHT: _____ AGE: _____

SPECIES: □ DOG □ CAT SEX: □ MALE □ NEUTERED MALE □ FEMALE □ SPAYED FEMALE

1) PLEASE DESCRIBE ALL CURRENT MEDICAL PROBLEMS THIS ANIMAL HAS: _____

_____

_____

2) PLEASE LIST ANY PAST MEDICAL CONDITIONS YOU ARE AWARE OF: _____

_____

3) HAVE YOU SOUGHT MEDICAL TREATMENT FOR PAST OR PRESENT ISSUES FOR THIS PET?:_____

_____

4) IF YES, PLEASE LIST ANY TREATMENT, RECOMMENDATIONS OR MEDICATIONS MADE OR PRESCRIBED:

_____

_____

_____

5) HOW LONG HAS THE CONDITION(S) BEEN PRESENT? _____

6) PLEASE LIST ANY VACCINATIONS THE PET AS RECEIVED? _____

_____

_____

7) HAS MONTHLY HEARTWORM PREVENTION BEEN ADMINISTERED? _____

8) IF YES, WHAT BRAND? _____

9) HAVE YOU ADMINISTERED ANY OTHER TREATMENTS, SUCH AS DEWORMER, MEDICATED BATHS, ETC? _____

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Please submit this completed form to CARE@ AAHPCR.com or fax to (910)-256-2981. Please include copies of any pertinent records including diagnostic tests and radiographs. The CARE board will review your request and respond within 7-10 business days. If additional information is needed to make a determination, we will contact you at the numbers you provide above.