

VETERINARY HEALTH

VISIT REPORT



PART 1

GENERAL INFORMATION

DOG NAME

DATE MM / DD / YYYY

HANDLER NAME

ROLE RAISER/SITTER/STAFF/CLIENT

PART 2

VETERINARIAN INFORMATION

VETERINARIAN NAME

CLINIC

BURQUITLAM

MACLEOD TRAIL

SPCA

CANADA WEST

FRASER VALLEY EMERG

FISH CREEK

OTHER:

ADDRESS (IF OTHER)

STREET

CITY

PROV

POSTAL CODE

PHONE

FAX

PART 3

MEDICAL

REASON FOR VISIT

TESTS ORDERED

TREATMENT/MEDICATION DISPENSED MEDICATION NAME, DOSAGE, FREQUENCY & DURATION

FOLLOW UP REQUIRED

YES

NO

FOLLOW-UP

MM / DD / YYYY

CURRENT WEIGHT

LBS

KG

IDEAL WEIGHT

DA2PP

MM / DD / YYYY

RABIES

MM / DD / YYYY

BORDETELLA

MM / DD / YYYY

STOOL SPECIMEN

EYES

EARS

TEETH

SKIN

PLEASE ATTACH ANY ADDITIONAL INFORMATION/REPORTS/VACCINATION CERTIFICATES & SUBMIT TO MEDICAL@PADS.CA

PART 4

OFFICE USE ONLY

MEDICAL SPREAD SHEET

GREEN SHEET

DOG'S MEDICAL FILE

IWDR