

Date: \_\_\_\_\_ Client: \_\_\_\_\_ Patient: \_\_\_\_\_

## Diabetic Drop-Off History and Consent Form

Last dose of insulin: \_\_\_\_\_ Insulin Type: \_\_\_\_\_ Amount Given: \_\_\_\_\_ Time: \_\_\_\_\_  
Time fed: \_\_\_\_\_ Food given and amount: \_\_\_\_\_ Amount eaten: \_\_\_\_\_

**Vomiting** (if yes, describe and give length of time): Yes/No \_\_\_\_\_

**Diarrhea** (if yes, describe and give length of time): Yes/No \_\_\_\_\_

**Eating:** Normal/decrease/increased/not eating \_\_\_\_\_ How long has there been a change? \_\_\_\_\_

**Drinking:** Normal/decrease/increased/not drinking \_\_\_\_\_ How long has there been a change? \_\_\_\_\_

**Urinating:** Normal/decrease/increased/not urinating \_\_\_\_\_ How long has there been a change? \_\_\_\_\_

Does he/she get up at night to urinate/is the litterbox more full than normal? \_\_\_\_\_

Is he/she having accidents in the house? \_\_\_\_\_

Changes in behavior (describe; i.e. more tired, sleeping more, hiding more, lameness, etc): \_\_\_\_\_

What is your general assessment of how your pet is doing with his/her diabetes? \_\_\_\_\_

Has your pet had any episodes of weakness, tremors, seizures? \_\_\_\_\_

Have you noticed any changes in your pet such as cloudiness to eyes, difference in walking/posture, changes in mental status (confusion or disorientation), weight loss? \_\_\_\_\_

Do you have any other concerns about your pet? Are you having any problems with your insulin or monitoring technique or equipment? \_\_\_\_\_

**Possible Additional Costs:** After an initial examination, we may recommend bloodwork, urinalysis, radiographs or other treatments or procedures. **PLEASE CHOOSE ONLY ONE OPTION**

- Perform any diagnostics or procedures that the Doctor feels necessary. I agree to assume financial responsibility for these charges.
- Call me after the physical exam and provide an estimate of any additional procedures. I understand that if I cannot be contacted at this number, necessary radiographs, bloodwork, or other diagnostic and or minor treatment procedures will be performed. I agree to assume financial responsibility for these additional charges. Major surgeries or medical procedures will not be performed until we are able to contact you.
- Recommended tests up to \$\_\_\_\_\_ then call (indicate maximum dollar amount you are willing to pay for recommended test before you wish to be called. This amount is for diagnostics only, not treatment. You will be called to discuss results of tests before treatment is started unless we are instructed otherwise.)
- Call me after the physical exam and provide an estimate of any additional diagnostics or procedures. Do not proceed without authorization. I understand that if I cannot be contacted at this number no diagnostics or other treatments or procedures will be performed and I will assume all responsibility for any complications this decision may cause for my pet.
- Blood glucose curve okay: \_\_\_\_ Yes \_\_\_\_ No

\_\_\_\_ Payment is expected when services are rendered. Should I fail to pay at any time any portion of the bill for my pet's care, I agree to pay the costs of all delinquency charges, collection charges and reasonable attorney's fees. I have read and understand this authorization of consent. I agree to pay the balance of all fees at the time of my pet's discharge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone number(s): \_\_\_\_\_