**Wellness Appointment**

**Cody’s Clinic at SPCA Westchester**

**590 North State Road, Briarcliff Manor, NY 10510**

*Please note, we will try our best to get you in for your appointment on time, however, due to the nature of the process, there may be a wait. Please have a cell phone and credit card or cash (checks are not accepted) with you at the time of your appointment.*

*Payment will be collected at the end of your appointment.*

*You must wear a mask to the appointment.*

*Cats must be in a pet carrier. Small dogs preferably in a pet carrier (or if not, on a leash). All other dogs must be on a leash.*

**The following forms *AND* up-to-date vaccination records *MUST* be completed and either emailed (Word or PDF documents only) to** [**clinic@spcawestchester.org**](mailto:clinic@spcawestchester.org)**, dropped off, or faxed back to us (914) 762-8312 at least 24 hours prior to the day of your appointment. If they are not, your appointment will be cancelled.**

Date and Time of Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_  
Email *(required)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: ( ) \_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Make/Model/Color of Vehicle (this will make it easier for us to identify you for

check-in): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pet’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ years \_\_\_\_\_ months

Animal: \_\_\_\_\_ Cat \_\_\_\_\_ Dog Sex: \_\_\_\_ Male \_\_\_\_ Female

Breed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spayed/Neutered: \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

Patient at clinic prior to today: \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

If yes, when and what for (i.e.: 2018 spay/neuter): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Most recent vaccination history (vaccine/yr.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*(VET FORMS MUST BE ATTACHED)\*

Please describe your pet’s temperament when vetted? Are they usually fearful, difficult, aggressive, shy, do they need to be muzzled, etc.? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following questions need to be answered and approved prior to your appointment. Please mark off your answer to each question. Please ***initial*** where indicated. Please be sure to ***sign*** and/or print your full name at the conclusion of the questionnaire

acknowledging that you have agreed to the terms, costs, and protocols set forth and to

be performed during your appointment. Please put an “X” next to your answer below.

* Do you acknowledge that you will be charged a mandatory exam fee of $35?

\_ Yes \_ No

* Since you will not be present in the exam room, do you consent for our vet to administer the requested vaccines/services that you have marked off below?

\_ Yes \_ No

* You will be required to have a cell phone with you during the appointment as our vet may call with any questions, if needed. Do you acknowledge and consent to this?

\_ Yes \_ No

* Do you agree to wear a mask for the safety of you and our staff?

\_ Yes \_ No

**Pet’s Health Questions:**

* Does your pet have any known medical issues, allergies or currently on any medications?

\_ Yes \_ No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have you noticed any increase or decrease in appetite or thirst?

\_ Yes \_ No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have you noticed any vomiting, diarrhea, coughing, sneezing, lethargy, limping,

itching or anything else abnormal?

\_ Yes \_ No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Has your pet bitten anyone in the past 10 days?

\_ Yes \_ No

* Will you be needing any flea and tick or heartworm preventatives?

\_ Yes \_ No

If yes, please let us know which ones you would like to purchase as well as the quantity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please put an “X” next to the services you would like for your pet:***

**Dog Services:**

\_$30 DHPP/Distemper Vaccine

\_$30 Bordetella

\_$45 4DX (Heartworm/Lyme/E.Canis) Blood Test

\_$30 Rabies Vaccine

\_$45 Lyme Vaccine

\_$35 Lepto Vaccine

**Dog Services:**

\_$30 DHPP/Distemper Vaccine

\_$30 Bordetella

\_$45 4DX (Heartworm/Lyme/E.Canis) Blood Test

\_$30 Rabies Vaccine

\_$45 Lyme Vaccine

\_$35 Lepto Vaccine

\_$45 Canine Influenza

\_$35 Microchip

\_$15 Dewormer (Liquid/Pill)

**Cat Services:**

\_$30 FVRCP/Distemper

\_$40 FELV Vaccine

\_$30 Rabies Vaccine

\_$55 FELV/FIV Blood Test

\_$70 Bartonella Test

\_$20 Small Profender (1yr Dewormer)

\_$25 Medium Profender (1yr Dewormer)

\_$35 Large Profender (1yr Dewormer)

\_$35 Microchip

\_$15 Dewormer (Liquid/Pill)

**Additional Services:**

\_\_$15-20 Nail Trim

\_\_$25 Anal Glands

\_\_$20 Ear Mite Check ($30 Ear Mite Check with Treatment)

\_\_$45 Accuplex

\_\_$40 Fecal/Giardia Test

\_\_$60 Preop CBC

\_\_$65 Urinalysis

\_\_$155 Vet screen CBC (pets 5 years and older)

\_\_$225 Senior Profile (pets 10 years and older)

***\*Please watch your pet for vaccine reactions for the next few hours: including, but not limited to swelling of face, vomiting/diarrhea & hives. If abnormalities occur, contact a vet immediately. \_\_\_\_\_\_\_\_\_\_\_\_ (Please Initial Here)***

To the best of my knowledge, the information stated on this form is true and accurate.

E-Signature of owner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVID19 Symptoms/Exposure Disclaimers**

If you or anyone you have come into contact with, are exhibiting any of the below symptoms, please contact our office immediately:

1. Dry cough
2. Fever greater than 100°
3. Any upper respiratory illness (sore throat, runny nose, congestion)
4. Loss of smell or taste
5. Shortness of breath

Please call our office to reschedule if any of the below apply to you:

1. Diagnosed with Covid-19 within the last 14 days of your appointment.
2. If you have come into contact with a Covid-19 positive person within the last 14 days of your appointment
3. If you have traveled to a state or territory on the NY State quarantine list within the last 14 days of your appointment

\*\*Please visit the following link for an up-to-date list\*\*https://coronavirus.health.ny.gov/covid-19-travel-advisory