Georgetown Veterinary Hospital

SAMPLE DROP OFF

Name: (owner)_____ Date_____

(pet) _____

Primary Veterinarian_____

Contact Number for Results_____

Urine_____

Reason for Analysis_____

When Sample was Obtained:

Date_____

Time_____

Refrigerated? Yes___ No___

Symptoms:

Straining Yes___ No___

Blood Yes___ No___

Vomiting Yes___ No___

How Frequent_____

Other_____

Urine appearance (describe)?

Duration of Problem?

Any change in diet?

On any medication?

Fecal_____

Reason for Analysis_____

When Sample was Obtained:

Date_____

Time_____

Refrigerated? Yes___ No___

Symptoms:

Straining Yes___ No___

Blood Yes___ No___

Vomiting Yes___ No___

How Frequent_____

Other_____

Fecal consistency (describe)?

Any abnormal material (parasites, etc.)

Duration of Problem?

Any change in diet?

On any medication?

Pre-Paid? Yes_____ No_____ Charges in? Yes_____ Employees Initials_____

Results_____