RIVERVIEW

ANIMAL HOSPITAL

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Fecal Drop Off Form

Date _______ Owner's Name ____________________________ Phone Number _____________
Pet's Name __________________ Pet's Age_________ Pet's Weight _______________

What time did you collect this sample? ______________ Was it refrigerated? ____________________
Is this a recheck? _________ Annual (routine) check? ____________

Symptoms (check all that apply)

☐ Diarrhea ☐ Vomiting ☐ Change in appetite ☐ Scooting ☐ Licking rear end

☐ Change in activity level ☐ Parasites seen in stool

When did you first notice these symptoms? ____

Since the symptoms started, has it gotten worse/better/the same? _____________________________

Has your pet been dewormed? ______ When was the last treatment? ___________________________

Is your pet on medications or over the counter supplements? _________________________________

Medications/Supplement Names: ____

Last time your pet had their medications? ____

Any known allergies to medications? If so, which ones? _______________________________

What brand of food do you feed? ____

Did you recently change anything in their diet (food, treats)? __________________________

If diarrhea, what is the color, consistency, and frequency? _____________________________

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Other concerns today? ____

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