RIVERVIEW

ANIMAL  HOSPITAL

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Urine 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?_____ How did you get the sample (caught midstream, off floor, urine beads, etc)?_____

Symptoms/Concerns Today (check all that apply)

☐ frequent need to urinate ☐ change in the amount of urine produced

☐ accidents in the house/not using litter box ☐ change in color of urine

☐ change in appetite ☐ change in water intake

When did you first notice these symptoms?_____

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

Has your pet had urine issues in the past? _____ When? _____

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?_____

Please explain appetite/thirst changes (more or less) _____

What brand of food do you feed?_____

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

Other concerns today?_____