



I-131 Patient Information Form

Owner Contact Information

Owner's Name: _____
 Spouse/Other's Name: _____
 Mailing Address: _____
 City: _____
 State/Zip: _____
 Home Phone: _____
 Bus Phone: _____
 Cell Phone: _____
 FAX: _____
 E-mail: _____

Referring Veterinarian

(If none, write "referred by self" and skip to "About My Cat")

Veterinarian: _____
 Hospital: _____
 Address: _____
 City: _____
 State/Zip: _____
 Phone: _____
 FAX: _____
 Date of last visit: _____

About My Cat

If you are referring more than one cat, please repeat this section for *each* cat. We need only your name on the top half of each additional cat's Referral Form. You do not have to repeat address, phones, etc.

Cat's Name: _____
 Cat's Nickname: _____
 Breed: _____ Eye Color: _____
 Age Now: _____ OR Date of birth: _____
 Declawed? _____ When: _____
 Coat Length: _____ Coat Color: _____

Sex: (check all that apply) Coat Condition: (check one)

<input type="checkbox"/> Intact Male <input type="checkbox"/> Neutered Male <input type="checkbox"/> Intact Female <input type="checkbox"/> Spayed Female <input type="checkbox"/> Used for Breeding	<input type="checkbox"/> Clean & Shiny <input type="checkbox"/> Dirty & Dull <input type="checkbox"/> Itchy with Hair Loss
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Condition of Teeth:

Clean
 Mild Tartar
 Gingivitis/Tartar
 Severe Gingivitis Tartar

Vomiting: <input type="checkbox"/> None <input type="checkbox"/> Rarely <input type="checkbox"/> Intermittent <input type="checkbox"/> Chronic	Diarrhea: <input type="checkbox"/> None <input type="checkbox"/> Intermittent <input type="checkbox"/> Chronic	Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Picky <input type="checkbox"/> Ravenous
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Urinary Habits: (check all that apply) <input type="checkbox"/> Uses Litterbox <input type="checkbox"/> Goes Outdoors <input type="checkbox"/> Housesoils	Temperament: <input type="checkbox"/> Outgoing/Social <input type="checkbox"/> Neutral <input type="checkbox"/> Shy <input type="checkbox"/> Aggressive <input type="checkbox"/> Scaredy Cat
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General Body Condition: <input type="checkbox"/> Emaciated <input type="checkbox"/> Thin <input type="checkbox"/> Normal <input type="checkbox"/> Chubby <input type="checkbox"/> Obese <input type="checkbox"/> Very Obese	Lifestyle: <input type="checkbox"/> Indoors <input type="checkbox"/> Indoors/Outdoors <input type="checkbox"/> Outdoors Only <input type="checkbox"/> Barn Cat <input type="checkbox"/> Feral/Stray
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Best Description of Your Relationship with your cat:

Best Friend Companion Housecat/Pet
 Barn Cat/Mouser Feral/Stray

Tested for FIV(AIDS): _____ When: _____
 Results: _____

Tested for Heartworm: _____ When: _____
 Results: _____

Taking Heartworm Medication: _____

Tested for Leukemia: _____ When: _____
 Results: _____

Last Vaccinated on: _____
 For What : _____

How long ago was your cat diagnosed with hyperthyroidism?

What are the clinical problems your cat is experiencing? For how long? (Give examples, such as "weight loss.")

Does your cat have any current problems with: (check all that apply)

- Appetite Heart Kidneys Liver Dental/Teeth
- Vision Hearing Vomiting Diarrhea Arthritis/Walking

Is your cat on Tapazole (Methimazole) or has your cat been on this drug within the last year? Yes No
Dates on and off this drug:

Is your cat on any medications or nutritional supplements?

What food(s) does your cat prefer to eat? Please be SPECIFIC! For example, "Purina ONE Dry, Salmon Flavor."

Dry _____

Canned _____

Pouch or Semi-Moist _____

Treats _____

Describe your family: adults, children, other kitties, other pets, pet sitters, etc.

Do you have any concerns about your cat's health?

Do you have any concerns about your cat's stay with us?

AUTHORIZATION AND ACCEPTANCE OF RESPONSIBILITY:

I hereby authorize Cat Specialist to examine, prescribe for, and treat the above describe cat. I assume responsibility for all charges incurred in the care of this pet. I agree to pay these charges, in full, at the time services are rendered, unless other arrangements are made prior to treatment. I understand that there is a deposit required prior to radio-iodine treatment, unless other arrangements are made prior to treatment.

Signature of Owner or Responsible Party _____ Date: _____