BLUE CROSS
Veterinary Hospital

Drop Off Information Sheet for the Diabetic Patient

Client Name _____ Patient_____ Date_____

It is very important that the doctor be able to reach you by phone while your pet is being tested.

Primary Person/Number _____ between the hours of _____

Alternate Person/Number _____ between the hours of _____

Please provide the following essential information as completely as possible:

Type of food your pet eats _____

What time(s) of day do you feed your pet? _____ am _____ pm or _____ free choice

What amount of do you feed at each meal? _____

Was your pet fed today? _____ No _____ Yes If yes, at what time? _____

Did your pet eat? _____Ate Well _____Ate Half _____Ate Some _____Did Not Eat

Does your pet receive any treats? _____ No _____ Yes

If yes, please list what type, the amount, and when they are given _____

How is water offered? _____ Free Choice _____ Measured – if so, how much? _____

Type of Insulin Given _____

What times of day is insulin administered? _____ am _____ pm Amount_____

Did your pet receive insulin this morning? _____ No _____ Yes

If yes, at what time? _____ What amount was given? _____

Have you noticed any changes in your pet's appetite? _____ eating more _____ eating less

Have you noticed any changes in your pet's drinking habits? _____ drinking more _____ drinking less

Have you noticed any changes in your pet's urination habits? _____urinating more _____urinating less

Have you noticed any changes in your pet's overall attitude/energy level? _____

Please list any other medications your pet is receiving, the dose, frequency, and when the last dose was given below:

Medication	Amount (dose)	Frequency (times given)	Last Given

Please tell us anything else you think may help us treat and/or help regulate your pet's diabetes

_____

_____

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