CRESTON VETERINARY HOSPITAL

Diabetic Drop-Off (for Boarding OR Blood Glucose Curves)

Date: _____

Patient Name: _____ Client Name: _____

Time(s) when you regularly feed your pet: ☐ AM ☐ PM

Amount of food fed at each sitting (wet/dry/treats): _____

Brand of food(s): _____

Has your pet eaten today? ☐ Yes ☐ No

If so, what and how much? _____

Dose of insulin your pet receives: ☐ units ☐ times a day.

Time of injections: ☐ AM ☐ PM

Type of insulin: _____ Type of insulin syringe used: _____

When was the last dose of insulin given?: ☐ AM ☐ PM

Did you bring your own insulin? ☐ Yes ☐ No

Did you bring your own food? ☐ Yes ☐ No

Have you noticed any changes in the following?			
	Increased	Decreased	Normal
Weight	☐	☐	☐
Appetite	☐	☐	☐
Thirst	☐	☐	☐
Urination	☐	☐	☐
Energy	☐	☐	☐

If so, please describe here:

Please note any changes in behavior (i.e. lethargy, sleeping more, hiding more, lameness, etc.):

_____

Any other concerns/illnesses (i.e. vomiting, diarrhea, weakness, disorientation, tremors, seizures, cloudy eyes, coughing or sneezing)? Please briefly describe:

_____

Please provide a phone number where you can be reached today: _____