

PVSEC -- Oncology Check-In Sheet

Client: _____

Patient: _____

Date: _____

What are your concerns for your pet?

General Health:

Appetite: Normal Increased Decreased | Water Consumption: Normal Increased Decreased
Urination: Normal Increased Decreased | Activity Level: Normal Increased Decreased

Vomiting: None Yes (If yes, Please fill out the information below)

Frequency of vomiting: 1/day 2-5/day 5 or more/day *** For how many days: _____

How many days after chemotherapy administration did the vomiting begin? _____

Has any medications/treatment been administered for the vomiting? Yes No

If Yes, what medication/treatment? _____

Diarrhea: None Yes (If yes, Please fill out the information below)

Describe the bout of Diarrhea: Blood Clear Mucous Straining Black Stool

Frequency of diarrhea: 1/day 2-5/day 5 or more/day *** For how many days: _____

Has any medications/treatment been administered for the diarrhea? Yes No

If Yes, what medication/treatment? _____

Current Medications: (Check REFILL if you need a refill for that medication)

<p><u>Anti-Nausea:</u> <i>How many</i> <i>Need</i></p> <p><i>Medication</i> <i>Given?</i> <i>How Often?</i> <i>Refill?</i></p> <p><input type="checkbox"/> Reglan (Metoclopramide) _____ _____ <input type="checkbox"/></p> <p><input type="checkbox"/> Cerenia _____ _____ <input type="checkbox"/></p>	<p><u>Stomach Protectant:</u> <i>How many</i> <i>Need</i></p> <p><i>Medication</i> <i>Given?</i> <i>How Often?</i> <i>Refill?</i></p> <p><input type="checkbox"/> Pepcid (famotidine) _____ _____ <input type="checkbox"/></p> <p><input type="checkbox"/> Sucralfate _____ _____ <input type="checkbox"/></p>
<p><u>Anti-Diarrhea:</u> <i>How many</i> <i>Need</i></p> <p><i>Medication</i> <i>Given?</i> <i>How Often?</i> <i>Refill?</i></p> <p><input type="checkbox"/> Immodium _____ _____ <input type="checkbox"/></p> <p><input type="checkbox"/> Flagyl (Metronidazole) _____ _____ <input type="checkbox"/></p>	<p><u>Appetite Stimulant:</u> <i>How many</i> <i>Need</i></p> <p><i>Medication</i> <i>Given?</i> <i>How Often?</i> <i>Refill?</i></p> <p><input type="checkbox"/> Mirtazapine _____ _____ <input type="checkbox"/></p> <p><input type="checkbox"/> Cyproheptadine _____ _____ <input type="checkbox"/></p>
<p><u>Chemo:</u> <i>How many</i> <i>Need</i></p> <p><i>Medication</i> <i>Given?</i> <i>How Often?</i> <i>Refill?</i></p> <p><input type="checkbox"/> Palladia _____ _____ <input type="checkbox"/></p> <p><input type="checkbox"/> Leukeran _____ _____ <input type="checkbox"/></p> <p><input type="checkbox"/> Cytoxan _____ _____ <input type="checkbox"/></p>	<p><u>Pain Meds</u> <i>How many</i> <i>Need</i></p> <p><i>Medication</i> <i>Given?</i> <i>How Often?</i> <i>Refill?</i></p> <p><input type="checkbox"/> Piroxicam _____ _____ <input type="checkbox"/></p> <p><input type="checkbox"/> Deramaxx _____ _____ <input type="checkbox"/></p> <p><input type="checkbox"/> Tramadol _____ _____ <input type="checkbox"/></p>
<p><u>Other</u> <i>How many</i> <i>Need</i></p> <p><i>Medication</i> <i>Given?</i> <i>How Often?</i> <i>Refill?</i></p> <p><input type="checkbox"/> Prednisone _____ _____ <input type="checkbox"/></p> <p><input type="checkbox"/> Benadryl _____ _____ <input type="checkbox"/></p>	<p><u>Other Medication and Supplements Not Listed:</u></p> <p><i>Medication</i> <i>How many</i> <i>Need</i></p> <p> <i>Given?</i> <i>How Often?</i> <i>Refill?</i></p> <p>_____ _____ _____ _____</p>

If Medication refills are needed: Fill Here (Hospital) Written Prescription Call into Pharmacy:

Pharmacy Name: _____

Client Signature: _____ Phone: () _____