PVSEC -- Oncology Check-In Sheet

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Client: _____ Patient: _____ Date: _____

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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)*

Anti-Nausea: *MedIcation*	*How many Given?*	*How Often?*	*Need Refill?*	Stomach Protectant: *Medication*	*How many Given?*	*How Often?*	*Need Refill?*
❑ Reglan (Metoclopramide)	_____	_____	❑	❑ Pepcid (famotidine)	_____	_____	❑
❑ Cerenia	_____	_____	❑	❑Sucralfate	_____	_____	❑

Anti-Diarrhea: *Medication*	*How many Given?*	*How Often?*	*Need Refill?*	Appetite Stimulant: *Medication*	*How many Given?*	*How Often?*	*Need Refill?*
❑ Immodium	_____	_____	❑	❑ Mirtazapine	_____	_____	❑
❑ Flagyl (Metronidazole)	_____	_____	❑	❑ Cyproheptadine	_____	_____	❑

Chemo: *Medication*	*How many Given?*	*How Often?*	*Need Refill?*	Pain Meds *Medication*	*How many Given?*	*How Often?*	*Need Refill?*
❑ Palladia	_____	_____	❑	❑ Piroxicam	_____	_____	❑
❑ Leukeran	_____	_____	❑	❑ Deramaxx	_____	_____	❑
❑ Cytoxan	_____	_____	❑	❑ Tramadol	_____	_____	❑

Other *Medication*	*How many Given?*	*How Often?*	*Need Refill?*	Other Medication and Supplements Not Listed: *Medication*	*How many Given?*	*How Often?*	*Need Refill?*
❑ Prednisone	_____	_____	❑				
❑ Benadryl	_____	_____	❑	_____	_____	_____	_____

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

Pharmacy Name:_____

Client Signature: _____ Phone:( )_____