Cushing's Disease Drop Off Form

Owner's Name: _____

Patient's Name: _____

Phone Number: _____

Your dog is coming in to assess the effectiveness of treatment with trilostane.

1. Date medication was last given: _____
2. Time medication was last given: _____

3. Do you typically give this medication with food? Please circle one:

YES NO

4. Was your pet fasted for at least 12 hours before dropping off? Please circle one:

YES NO

5. Has your pet experienced any of the following? Please circle:

VOMITING DIARRHEA LETHARGY OTHER (please describe below):

_____

_____

6. Have the symptoms of Cushing's Disease (such as bloated abdomen, panting, excessive eating, drinking and/or urination, thinning fur) improved?

YES NO

_____

Signature Date