Pet's Name: **Owner:** **Date:**

Gender: **Breed & Color:** **Age:**

ILLNESS OR INJURY – DAY ADMISSION APPOINTMENT

Your pet's doctor or nurse will be calling you to review your pet's health status and to recommend a Treatment Plan.
Please list the phone number(s) where we can reach you today:
→

CURRENT MEDICATIONS & SUPPLEMENTS (ORAL & TOPICAL):

Medication/Supplement	Dose	Dosing Frequency*	Last dose given	Next dose due
1				
2				
3				
4				
5				

*Q12H = every 12 hours or twice daily, QDAM = once in morning, QDPM = once in evening

ALLERGIES: Please list any known medication or food allergies or sensitivities:_____

DIET & APPETITE: Please describe your pet's current diet, treats, and appetite.

- What do you feed your pet (type, brand, amount, frequency):
- When did your pet last eat?
- Appetite – increased, decreased, by what percent of normal?
- Has there been a recent change in your pet's diet or treats? Did your pet eat something s/he shouldn't, such as trash, medication, raisins, plants, poison, or another animal's stool?

FLEAS: We are dedicated to providing a *Flea Free Environment* for our patients. All pets are checked for fleas upon entry and discharge. If fleas are found on your pet, we will administer an appropriate flea treatment at an additional cost.

MORE INFORMATION:

☐ I would like the ability to access my pet's medical records, lab results, and discharge instructions online.

☐ I would like more information about pet insurance.

YOUR PET'S PROBLEM OR CONCERN: Briefly describe your pet's problem/concern. When did you first notice the problem? Is the problem getting worse, better, or about the same?

RECENT CHANGES IN YOUR PET: Please check any recent changes in your pet's condition, and then describe them in detail on the back of this page

- ☐ Behavior, activity level, sleeping habits
- ☐ Weight change – in what time frame?
- ☐ Injury – laceration or wound
- ☐ Gait, limping, or lameness – which leg(s)?
- ☐ Water consumption – increased, decreased?
- ☐ Urination – amount, quality, frequency?
- ☐ House soiling or incontinence
- ☐ Stool - amount or consistency
- ☐ Breathing or coughing
- ☐ Sneezing – any nasal discharge?
- ☐ Pain – where?
- ☐ Difficulty rising or jumping?
- ☐ Vomiting – frequency, how soon after meal?
- ☐ Skin or hair coat changes? Lump? Wound?
- ☐ Stumbling or falling
- ☐ Seizures – describe frequency & length
- ☐ Change in home environment?
- ☐ Exposed to new pets? Daycare or parks?
- ☐ Shaking head or scratching ears
- ☐ Itchiness or scratching body?
- ☐ Near a stream, lake or ocean beach?
- ☐ Travel outside Seattle?

PERMISSION TO EXAMINE & TREAT: I give the doctors of Atlantic Veterinary Hospital permission to examine my pet.

- ☐ I authorize necessary diagnostic tests and treatments up to $_____

- ☐ I do not authorize any diagnostic testing or treatment without first discussing the recommended Treatment Plan with the doctor. *I understand that if I cannot be reached by phone, no testing or treatment will be performed except in case of a life-threatening emergency. I will be responsible for the costs associated with emergency care.*

PICK-UP TIME REQUEST: What time would you like to pick-up your pet? _____
We will do our best to accommodate your request, but ask for your understanding if the care of your pet and our other patients does not allow it. *Please advise us of any special circumstances in regard to today's appointment.*

Owner/Authorized Agent: *(please print)* _____

Signature: _____

Date: _____

****This form must be thoroughly completed and signed to initiate care.****

Payment in full is required at patient discharge.

It's a pleasure to care for you and your pet. Thank you!