

Patient Admittance Form

Today's Date: _____

Place chart label here

Number where we may reach you today:
(____) _____ - _____

Alternative number if available
(____) _____ - _____

Reason for your visit today, be specific: _____

Please list all of your pet's symptoms: _____

Is this a new problem? _____ If so, how long? _____

Has your pet eaten today? _____ If so, what? _____

Is this your pet's usual diet? _____ If not what is? _____

Is your pet's appetite: Normal Increased Decreased (circle one).

Is your pet's water intake: Normal Increased Decreased (circle one).

Is your pet on any medications? _____ If so, what and how often? _____

• When was it last given? _____.

Do you use flea control products? _____ If so, what kind? _____

Do you use heart worm control products? _____

Are there any other procedures you would like us to perform today? (i.e. pedicure, flea control, fecal exam, bath, vaccine boosters, etc.)

• If so, please list: _____

Please choose one of the following:

- I authorize ANY charges which the doctor deems necessary to diagnose/treat my pet's condition.
- I authorize up to \$_____ in charges to diagnose/treat my pet, if the charges exceed this amount, please call me at the above number(s).
- Please call me at the above number(s) prior to performing ANY diagnostics/treatment on my pet except for what is specified above.

To effectively diagnose and treat many problems, radiographs, blood tests, sedative, anesthetics and other procedures may be required. We will notify you before undertaking these tasks as to their need and cost, unless you specify at drop-off time. In the event of a life-threatening condition, we will make every attempt to stabilize your pet and then notify you as soon as possible as to the extent of the problem. There are not staff on the premises 24 hours a day and pets will be unsupervised during the overnight hours. Critical cases requiring close overnight monitoring may require transfer to an emergency animal hospital.

Signature _____ Date _____

THIS FORM WITH YOUR SIGNATURE GIVES US PERMISSION TO FOLLOW YOUR INSTRUCTIONS.

AUTHORIZATION TO PERFORM CARDIOPULMONARY
CEREBRAL RESUSCITATION (CPCR)

In the event that something should happen to my pet requiring cardiopulmonary cerebral resuscitation (CPCR) under the care of Plaza Del Amo Animal Hospital, I _____, hereby authorize the following for my pet:

_____ I authorize cardiopulmonary cerebral resuscitation (CPCR) to be Performed on my pet, at which time I will be contacted regarding further treatment.

Minimally Invasive; Resuscitation including any combination of the following; chest compressions, oxygen therapy, intubation, intravenous medications, catheterization and monitoring blood pressure, respiration and general responsiveness.

Invasive; Rarely, it is necessary to use invasive measures to resuscitate a patient. Invasive measures could involve manual manipulation of the heart, tracheotomy or venous cut downs in order to place a catheter.

_____ I do not want cardiopulmonary cerebral resuscitation (CPCR) to be performed on my pet.

_____ I have been informed of the minimum additional fee of \$300-\$400. for CPCR.

Client Signature

Date

Hospital Representative

Date