20 Park Place, Suite 1
Shippensburg, PA 17257
717-477-8938

PATIENT ADMITTANCE AND PERMISSION FOR DIAGNOSTIC TESTING

Patient Name: _____ **Client Name:** _____ **Date:** _____

We will need to be able to contact you/someone with permission to make medical and financial decisions.
1st Phone Number: _____ **2nd Phone Number:** _____

Primary Concern for appointment today: _____

_____

How long has the primary concern been going on: _____

Other Concerns: _____

Is your pet experiencing:
☐ Coughing ☐ Sneezing ☐ Discharge from Nose/Eyes ☐ Vomiting ☐ Diarrhea

☐ Itching/Scratching ☐ Trouble Walking or Moving ☐ Pain ☐ Wound(s)

Describe your pet's urination and defecation habits:

☐ Normal	☐ Formed Stool	Color of stool: _____
☐ Increased Urination	☐ Semi-formed Stool	
☐ Decreased Urination	☐ Watery Stool	Change in amount of stool: yes/no

When did your pet last eat: _____
What did you last feed your pet: _____

What do you normally feed your pet:

Dry food: Brand: _____ How Much: _____ How Often: _____
Canned Food: Brand: _____ How Much: _____ How Often: _____

Is your pet taking any medications? Please list medication, amount given and how often it is given:
_____
_____

Is your pet taking any supplements? Please list supplement, amount given and how often it is given:
_____
_____

In order to diagnose your pet's condition, your pet may require blood tests, x-rays, and/or other diagnostic testing. Do you authorize tests if the doctor feels it is warranted? Please initial below:
_____ YES, proceed with any doctor recommended diagnostic testing.
_____ NO, please contact me prior to performing any diagnostic testing.

I, undersigned owner/agent of the below named and admitted patient, hereby authorize the attending Veterinarian(s), her/his designated associates, assistants and staff to perform diagnostic procedures as they determine necessary for the care of my pet, including but not limited to blood tests, X-rays or other procedures as needed. Further, I authorize the attending Veterinarian(s), her/his designated associates, assistants and staff to administer such treatment as deemed therapeutically necessary. I also authorize the use of anesthetic agents if needed. Should an anesthetic be necessary, I authorize the placement of an intravenous catheter (if needed) to minimize the risk of anesthesia. I grant you my consent to receive, prescribe for, treat and/or operate upon my pet. You are to use all reasonable precautions against injury, escape or death of my pet, but you will not be held liable or responsible in any manner in connection there with as it is thoroughly understood that I assume all risks.

I understand that the attending Veterinarian will make a reasonable attempt to contact me prior to above-mentioned therapeutic procedures being performed. However, failure to complete said connections shall in no way reverse this authorization for treatment. I understand that no guarantee of successful treatment is made, and hereby verify that I have read and fully understand this authorization. Further, I assume financial responsibility for all charges, and agree to pay all charges at the time of the release of my pet from hospital care.

Since we are a multi-vet practice, I understand my pet may be seen by more than one veterinarian. Visitation may be available during my pet's stay and I understand that due to the nature of the hospital setting emergency conditions may alter the length of time or time(s) of day available. It is necessary that I call and confirm visitation before my arrival. Visitation is not allowed for any patient in isolation. I am welcome to call the hospital and speak to a technician during business hours regarding my pet and understand that any diagnoses can only be made by a doctor. A doctor or technician will make every attempt to update me at least once daily during my pet's stay.

In the unfortunate event of cardiopulmonary arrest, I authorize the doctor and medical staff to:

____ **RESUSCITATE:** Perform any resuscitation effort including chest compresssions, oxygen therapy and life-saving medications the doctor deems necessary and is within the realms of our clinic's capability to aide my pet, including emergency surgery.

____**DO NOT RESUSCITATE (DNR)**

DATE:_____CLIENT:_____

PATIENT: _____

REASON ADMITTED: _____

I understand there are doctor(s) or staff member(s) in the building during business hours that are assigned to my pet's care. After hours monitoring via remote surveillance is utilized by our on call staff. 24 hour monitoring is available at an emergency clinic in Hagerstown, Maryland. If your pet needs close monitoring, our veterinarian may recommend your pet be transferred there overnight. It may be necessary for our doctors to contact you concerning your pet's status at any time during their hospitalization with us. Please provide any phone numbers that we may need during your pet's stay.

I understand that throughout my pet's hospital stay additional costs may be incurred and that all fees are due when services and medications are rendered and will be paid in full at the time of my pet's discharge from the hospital.

I HAVE READ AND UNDERSTAND THIS AUTHORIZATION AND CONSENT

_____ _____

Owner's Name (Print) Owner's Name (Signature)