IN-PATIENT RELEASE

Owner's Name: _____ Date: _____
Pet's Name: _____

Address, Phone or Employment Corrections? □ Yes □ No Changes are:
Street Address: _____
City/State/Zip: _____
Phone: _____
My pet is being dropped off for the following reason/treatment: _____
_____
Duration of the problem: _____
Location of the problem: _____
Is your pet currently on medication? □ Yes □ No
Name of medication: _____
Dosage: _____ Last Given: _____

History

Yes No

□ □ Did your pet eat this morning?
□ □ Was food offered?
□ □ May we sedate/anesthetize your pet if necessary
□ □ Has your pet had any reaction to medications?
□ □ Has your pet had any reaction to vaccines?
□ □ Has your pet had any reaction to anesthesia?

Has your pet shown any sign of the following:

□ Vomiting? How long? _____
□ Diarrhea? How long? _____
□ Lethargy? How long? _____
□ No Appetite? How long? _____
□ Weakness? How long? _____
□ Coughing? How long? _____
□ Gagging? How long? _____
□ Scratching? How long? _____
□ Shaking Head? How long? _____
□ Scooting? How long? _____
□ Seizures? How long? _____
□ Urinating more or less than usual?
How long? _____
□ Limping? Which leg? _____
How long? _____
□ Weight loss or gain? _____
□ Unusual lumps or bumps? _____

CONSENT:
I agree to the following procedures:_____
In the event of an emergency or if further diagnostics are needed, we will make our best effort to reach you. However, should we be unable to reach you, please choose and initial one of the following choices:

□ I **DO** authorize additional treatment without my consent
□ Do whatever is needed.
□ Up to $_____ in additional treatments beyond what is stated above.
□ I **DO NOT** authorize additional treatment of ANY kind beyond what is stated above without my consent.

I understand that, if I decline additional treatment, Grand Avenue Veterinary Hospital cannot legally continue diagnostics or treatment other than that described above or already approved on consent form. If I do not select either option, Grand Avenue Veterinary Hospital cannot legally continue diagnostics or treatment other than the described above. If I authorized additional treatment, I understand that I am fully responsible for any charges occurred for the diagnostics of my pet and agree to pay in full at the time services are rendered.

How may we reach you today? _____

_____
Signature of Owner or Authorized Agent

Grand Avenue Veterinary Hospital