



## Admission Form

Client Name: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Alternative Phone: \_\_\_\_\_

Please list **all** surgical procedures to be performed on your pet. **Please specify location (e.g. left front leg, right side of abdomen), size, quantity, and duration.** If applicable, please mark area on the diagram below.

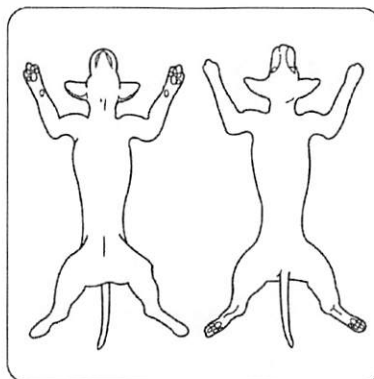
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### CURRENT HEALTH:

Please evaluate the following signs in your pet over the past week:

- |               |                                 |                                   |                 |
|---------------|---------------------------------|-----------------------------------|-----------------|
| (1) Appetite  | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | Describe: _____ |
| (2) Vomiting  | <input type="checkbox"/> YES    | <input type="checkbox"/> NO       | Describe: _____ |
| (3) Stools    | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | Describe: _____ |
| (4) Coughing  | <input type="checkbox"/> YES    | <input type="checkbox"/> NO       | Describe: _____ |
| (5) Breathing | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | Describe: _____ |
| (6) Urination | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | Describe: _____ |
| (7) Energy    | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | Describe: _____ |
| (8) Weight    | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | Describe: _____ |

**MEDICATIONS:**

Has your pet ever had a reaction to a medication (injection, suspension, or pill)? ☐ YES ☐ NO

If yes, please list medication: \_\_\_\_\_

Please list all medications (including supplements) that your pet is currently taking.

MEDICATION NAME	STRENGTH (mg)	DOSAGE (e.g. 1 tab twice daily)	TIME MEDICATION WAS LAST GIVEN

**DIET:**

Current diet? \_\_\_\_\_

At what time did your pet last eat? Date: \_\_\_\_\_ Time: \_\_\_\_\_

At what time did your pet last drink water? Date: \_\_\_\_\_ Time: \_\_\_\_\_

**ADDITIONAL INFORMATION:**

Please list any addition information that you think may be important for us to be aware of in regards to your pet's surgery today. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CONTACT INFORMATION:**

We need to be able to reach you **IMMEDIATELY** for questions regarding your pet's anesthetic procedure today, and in the case of an emergency. Please provide the name(s) and phone number(s) that either you or another individual able to make decisions on your behalf for today can be reached.

Primary Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Alternate Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**FINANCIAL ACKNOWLEDGEMENTS**

Please be advised that payment is due at the time of services rendered. **We do not accept checks from new clients.** New clients are to pay by cash and/or debit and credit card only. We do not offer payment plans or extent credit. I agree to pay a deposit of 100% of the outstanding charges and/or estimated fees, as discussed verbally or written by the veterinarian or hospital staff. I agree to assume financial responsibility for the remaining fees and will provide payment via cash, credit card, check, or Care Credit at the time my pet is discharged from the hospital. In the event it should become necessary to place any unpaid balance due for services rendered to me for collection, I agree to pay interest at the rate of 10% per month, or every 30 days.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Consent to Treatment

Please initial ALL that apply to acknowledge that you understand and authorize the terms below.

\_\_\_\_\_ Pre-anesthetic bloodwork is required, not optional, for any animal to ensure the use of the safest anesthetic possible. This will test for anemia, kidney or liver disease, and dehydration which could alter my pet's response to anesthesia.

\_\_\_\_\_ I understand that some risks always exist with anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before the procedure is initiated. Should unexpected life-saving emergency care be required and the attending veterinarian is unable to reach me, the hospital staff has my permission to provide such treatment, and I agree to pay for such care.

\_\_\_\_\_ I consent to the examination of my pet by staff veterinarians at Saguaro Veterinary Clinic. I also agree that after my consultation with the doctor and/or staff, the hospital's doctors may prescribe medication for, treat, hospitalize, sedate, anesthetize, and/or perform surgery on my pet, and that I am financially responsible for all charges due. I agree that either I, or an authorized agent of mine, will pay for all accrued charges at or before the time that services are rendered.

\_\_\_\_\_ I understand that veterinary care and the continuous presence of hospital staff and/or the veterinarian(s) during nighttime hours and/or weekends is not provided. Therefore, my animal left in the hospital for medical or surgical treatment during the hours of operation intentionally and/or unintentionally after hours will not be in the continuous presence of care. Normal hours of operation are Monday through Friday 7:00 a.m. to 5:00 p.m.

\_\_\_\_\_ I certify that I am eighteen years of age or over, and agree that either I, or an authorized agent of mine, will pick up my pet when he/she is ready to be released from the hospital. I acknowledge the hours of operation at Saguaro Veterinary Clinic and agree that if I fail to comply with this policy, the hospital may consider this action as abandonment and will handle the abandonment in a manner that is in the best interests of my pet and the hospital.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_