

GoldenView Veterinary Hospital Drop-Off Admission Form

Date: ___/___/___

Owner Name: _____

Pet's Name: _____

Problem(s) for which your pet needs to be seen: _____

_____ When was the problem first noticed? _____

Has the problem gotten worse? yes no If yes, how? _____

Has your pet vomited? yes no If yes, please describe _____

Has your pet had diarrhea? yes no If yes, please describe _____

Has your pet had any unusual coughing or sneezing? yes no If yes, please describe _____

What did your pet eat/drink last, and when? (Day and Time) _____

List any medications given to your pet within the last week: (Check here & use the back if more than 3 were given)

Medication:	How Much (Strength):	When Given:

Beyond examination, some tests may be required to effectively diagnose and treat your pet for the above problem(s). I understand that if emergency medical care is needed, my pet will receive the treatment that is necessary while every attempt to contact me is made. Please choose **ONE** option below as to how you would like the doctor to proceed:

A _____ I authorize the doctors/staff of GoldenView Veterinary Hospital to perform any diagnostic tests, treatments, and/or sedation/anesthesia deemed necessary for my pet.

OR

B _____ I authorize any tests/treatments deemed necessary, but I would like to be contacted for further authorization if the charges are expected to exceed \$_____.00.

OR

C _____ I prefer to be contacted after the doctor has examined my pet to discuss any testing or treatment that will be recommended, before it is done.

If I selected option B or C, I understand I may need to sign an additional authorization for medical care. Please fax or email the Treatment Plan to _____. I will sign and return the Treatment Plan to authorize the care and acknowledge the expected fees.

Signature of Owner/Authorized Agent _____

<first-name> <last-name>

<date>

Best phone number(s) to contact you: _____