San Carlos ANIMAL HOSPITAL
619.460.3100 | SDpetdoc.com

Patient Day Admittance Form

Your name: _____ Patient's name: _____
Briefly describe the reason for your pets visit today:

_____

*Is this a recurring issue with your pet? Yes / No
*How long has this issue been going on? _____
Please answer the following questions: This information is very important for the doctor to make accurate assessments.
*When is the last time you fed your pet? _____
*Has your pet been coughing? Yes / No
*Has your pet been sneezing? Yes / No
*If yes, have they been to a pet park, boarding facility, or have had contact with other pets? Yes / No
*Has your pet been vomiting? Yes / No
*Has your pet had diarrhea recently? Yes / No
*How has your pet's appetite been? Increased / Decreased / Normal
*How has your pet's thirst been? Increased / Decreased / Normal
*How is your pet's urination? Increased / Decreased / Normal
*How is your pet's defecation? Increased / Decreased / Normal
*How is your pet's activity level? Increased / Decreased / Normal
*Diet, amount and frequency of feeding? _____
*Is your pet currently on any flea prevention? Yes / No If so, which kind?
*Is your pet currently on any heartworm prevention? Yes / No If so, which kind?
*Is your pet on any other form of medications or supplement? If so, please tell us the name and dose.

_____

***Do you have any other questions or concerns to address?**

_____

In the event a medical/surgical decision must be made for the diagnostic or therapeutic care for your pet, and we are unable to contact you; how would you like us to proceed? *Please Initial*

_____ Proceed with care at the discretion of the doctor (additional charges will apply) (You understand that this may mean performing a procedure and may cause your pet prolonged or possible anesthesia)

_____ Do not proceed (You understand that this may mean not performing a procedure and may cause your pet prolonged or additional anesthesia)

Please understand that we will make every attempt to contact you should any unforeseen issues arise today. However, in the event of an unforeseen critical emergency, please elect what life-saving measures you would like performed so that we may be in accordance with your wishes: (these are at additional cost). *PLEASE INITIAL:

_____ Do NOT perform CPR
_____ Perform CPR life support measures (chest compressions, artificial respiration, IV medications, intubation, and IV fluids- Please know that additional charges will apply)

_____
Print Name (First, Last)

_____ _____
Signature of Responsible Party Date

****PLEASE NOTE OUR BUSINESS HOURS ARE MON-FRI 7 AM – 5:30 PM**