ARRIVED: CSR::

APT: DR:

DAY ADMIT INFORMATION SHEET

You will be leaving your pet at **All Pets Veterinary Hospital**. One of our doctors will examine your pet as soon as time is available, it may be after 2pm. If this is an urgent case ***please notify the front desk team member*** so they can inform the medical staff.

To provide better care for your pet, please take the time to describe the problem(s), including how long the problem has been present. _____

_____

OWNER _____

PET _____

DATE _____ ID# _____

(Office Use: Apply Label Here)

CHECK OFF THE QUESTIONS THAT PERTAIN TO YOUR PET'S PROBLEM

MANAGEMENT: ❑ Indoor ❑ Outdoor ❑ Indoor/Outdoor ❑ Direct contact with other animals

APPETITE: ❑ Normal ❑ Increased ❑ Decreased

WHEN did your pet last eat and WHAT is the diet_____

WEIGHT:	❑ Normal	❑ Increased	❑ Decreased
WATER INTAKE:	❑ Normal	❑ Increased	❑ Decreased
URINATION:	❑ Normal	❑ Increased	❑ Decreased
STOOLS:	❑ Normal	❑ Increased	❑ Decreased
ACTIVITY:	❑ Normal	❑ Increased	❑ Decreased

VOMITING: ❑ No ❑ Yes If yes, how often? ❑ Daily ❑ Once a week ❑1-2x's/mos ❑ > Monthly
Duration? ❑ Days ❑ Weeks ❑ Months ❑ Years

DIARRHEA: ❑ No ❑ Yes If yes, how often? ❑ Daily ❑ Once a week ❑1-2x's/mos ❑ > Monthly
Duration? ❑ Days ❑ Weeks ❑ Months ❑ Years

COUGHING/ SNEEZING: ❑ No ❑ Yes If yes, how often? ❑ Daily ❑ Once a week ❑1-2x's/mos ❑ > Monthly
Duration? ❑ Days ❑ Weeks ❑ Months ❑ Years

BAD BREATH/ DROOLING: ❑ No ❑ Yes If yes, how often? ❑ Daily ❑ Once a week ❑1-2x's/mos ❑ > Monthly
Duration? ❑ Days ❑ Weeks ❑ Months ❑ Years

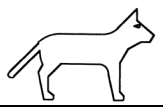
LIMPING: ❑ No ❑ Yes Which leg? ❑ Front Rt ❑ Front Lt ❑ Back Rt ❑ Back Lt
If yes, Duration? ❑ Days ❑ Weeks ❑ Months ❑ Years

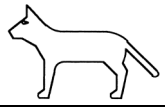
MEDICATION(S): ❑ No ❑ Yes What and when last given_____

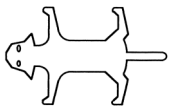
FLEA CONTROL: ❑ No ❑ Yes What and when last given_____

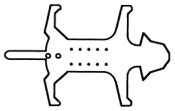
SKIN CHANGES: ❑ No ❑ Yes Describe the change and duration_____

SKIN GROWTH: ❑ No ❑ Yes Mark location on picture


Right


Left


Top


Underside

I authorize and request an examination for my pet. I understand an All Pet's doctor or team member will contact me after my pet has been examined. ***IT IS OF UTMOST IMPORTANCE THAT WE HAVE A PHONE NUMBER WHERE YOU CAN BE REACHED TODAY, THAT NUMBER(S) IS***_____

If the hospital staff calls *and cannot reach me by phone* I authorize:

- ❑ Initial diagnostics, including blood work and radiographs, if indicated for my pet.
- ❑ Initial treatment, including fluid support, pain management and other supportive medications, if indicated for my pet.
- ❑ Anesthesia, surgery and medications if needed for an abscess, laceration or wound repair. I understand and accept that when anesthesia is involved there is always and inherent risk, including death.
- ❑ Do not perform any procedure without contacting and giving an estimate.
- ❑ I understand payment is due when my pet is discharged and accept financial responsibility for charges incurred for my pet.

Signature: _____ Date: _____

Owner or Owner's Agent