C. C. Veterinary Hospital
HOSPITALIZATION RELEASE

Date: ______________________ File: _________________

Patient Information

Name: ____________________

Canine / Feline M / F

Spayed / Neutered

Breed: _____________________

Weight: _________ Age: ________

Client Information

Name: ____

**Phone Numbers: _____________________

____

____

****WE MUST BE ABLE TO CONTACT YOU WHILE YOUR PET IS HOSPITALIZED**

Main reason for today's visit:

____

Medications your pet is currently taking:

____

Does your pet chew or ingest items other than food? YES / NO

Is your pet fed table scraps/human food, and if so, what & how often? YES / NO

____

Is your pet exposed to toxic chemicals: anti-freeze, rat poison, cleaning agents, etc.? YES / NO
If yes, please specify:

____

In order to diagnose & treat your pet we may need to run in-house blood work, take radiographs, place an IV catheter for fluid administration, administer medications, etc. Estimates for most of these basic procedures are as follows (checks are placed next to planned procedures for today's visit):

___	Exam:	$54	
___	Recheck Exam:	$30	
___	Blood Work:	FULL Panel: $65	MINI Panel: $49
		CBC: $33	PCV: $6
___	Radiographs:	$80 - $115	
___	IV Fluids:	$46	
___	Hospitalization:	$27-$31/day	
___	Medication:	Varies	

Additional Procedures:

_________________________ $__________
_________________________ $__________
_________________________ $__________
_________________________ $__________
_________________________ $__________

Please circle any changes seen at home, and note when you first noticed these changes.

GENERAL ATTITUDE

- ☐ Bright
- ☐ Quiet
- ☐ Depressed
- ☐ Other

____

____

First noticed:

____

APPETITE

- ☐ Normal
- ☐ Increased
- ☐ Decreased
- ☐ Not Eating

Food normally given:

____

First noticed:

____

DRINKING

- ☐ Normal
- ☐ Increased
- ☐ Decreased
- ☐ Not drinking

First noticed:

____

CHECK ALL THAT APPLY

- ☐ Sneezing
- ☐ Coughing
- ☐ Gagging
- ☐ Choking
- ☐ Weight loss
- ☐ Weight gain
- ☐ Shaking

First noticed:

____

BOWEL HABITS

- ☐ Normal
- ☐ Soft / Loose
- ☐ Diarrhea
- ☐ Mucous
- ☐ Blood
- ☐ Straining
- ☐ Hard stool
- ☐ Constipated

First noticed:

____

URINATION

- ☐ Normal
- ☐ ↑ amount
- ☐ ↑ frequency
- ☐ ↓ amount
- ☐ ↓ frequency
- ☐ Blood

Changes in litterbox habits:

____

First noticed:

____

VOMITING

- ☐ Blood
- ☐ Food
- ☐ Phlegm

Color:

____

Amount:

____

First noticed:

____

MOUTH/TEETH/GUMS

- ☐ Swollen
- ☐ Drooling
- ☐ Odor
- ☐ Blood

First noticed:

____

EYES

- ☐ Vision Loss
- ☐ Swollen
- ☐ Discharge
- ☐ Cloudy
- ☐ Redness
- ☐ Squinting

First noticed:

____

EARS

- ☐ Scratching
- ☐ Painful
- ☐ Hearing loss
- ☐ Odor
- ☐ Discharge

First noticed:

____

SKIN

- ☐ Odor
- ☐ Itching / Scratching
- ☐ Wounds / Injuries
- ☐ Hair loss
- ☐ Lumps

Location:

____

First noticed:

____

MUSCULOSKELETAL

- ☐ Lameness
- ☐ Painful
- ☐ Head Tilt
- ☐ Physical trauma

Location:

____

First noticed:

____

ENVIRONMENT

- ☐ Indoors only
- ☐ Inside / Outside
- ☐ Outdoors

PLEASE TAKE A MOMENT TO READ & INITIAL EACH SECTION

Owner / Authorized Agent Release

***** We MUST be able to reach you WHILE your pet is under anesthesia. If for any reason contact cannot be made at the phone number provided, the veterinarian may perform procedures necessary for the health of the patient.**

X _____I understand C.C. Veterinary Hospital cannot guarantee the health of my pet. I understand that anesthesia and surgery always involves some risk (such as unknown internal physical abnormalities, medication allergies, surgical complications, including death, internal bleeding, shock, incision dehiscence, and post-surgical infection), and agree to hold C.C. Veterinary Hospital harmless, in the absence of negligence, in connection with these procedures. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

X _____If unforeseen conditions arise which, in the judgment of the attending veterinarian, require procedures and/or treatment other than those authorized in this release, and staff are unable to contact me or my authorized agent at the phone numbers listed above, I assume full responsibility for treatment expenses incurred.

X _____I understand that if I, the owner or authorized agent, do not contact C.C. Veterinary Hospital regarding the animal noted on this release after 5 days of the pet's admission to C.C. Veterinary Hospital, said animal will be considered abandoned and may be disposed of as the veterinarian sees appropriate. It is also understood this action does not relieve me of any debt to C.C. Veterinary Hospital for expenses incurred.

X _____All procedures must be paid in full at the time of service by cash, check, VISA, MasterCard, Discover, or Care Credit, unless prior arrangements have been made and approved.

X _____ I give C.C. Veterinary Hospital's doctor's and staff permission to provide services/procedures listed on page 1 of this document

X _____If fleas are observed on your pet while they are hospitalized, a Capstar pill will be administered to them at the owner's expense of $8.00.

X _____I have seen estimates for procedures / treatments my pet may receive (see page 1). I understand this is only an estimate and may be subject to change.

$ ________________ minimum charge

I am the owner / authorized agent of the animal described on this form and have the authority to execute this document. After carefully reading the above, I sign in agreement:

X ____ Print Name: ____