



ST. ANNA VETERINARY CLINIC, S.C.

DAY ADMIT FORM

CLIENT/PATIENT LABEL

Date: _____

Chief Complaint/Reason for Visit and when did it start? _____

Did your pet eat or drink today? ☐ No ☐ Yes When? _____

Is your pet on any medications or supplements? ☐ No ☐ Yes If so, please list: _____

Does your pet have any known medical condition or history of seizures? _____

Any injury or illness in the last 30 days? _____

Is your pet kept: ☐ Indoors ☐ Outdoors ☐ Both

Appetite:

☐ Normal
☐ Increased
☐ Decreased

Weight:

☐ Stable
☐ Gain
☐ Loss

Water Intake:

☐ Normal
☐ Increased
☐ Decreased

Stool:

☐ Normal
☐ Diarrhea
☐ Constipated
☐ Straining

Urination:

☐ Normal
☐ Increased
☐ Decreased
☐ Straining

Vomiting? ☐ No ☐ Yes

Lack of Energy? ☐ No ☐ Yes

Coughing/Sneezing? ☐ No ☐ Yes

Gagging? ☐ No ☐ Yes

Scotting? ☐ No ☐ Yes

Bad Breath? ☐ No ☐ Yes

Scratching? ☐ No ☐ Yes, location and how long? _____

Any unusual lumps or bumps? ☐ No ☐ Yes, location? _____

Any unusual discharge? ☐ No ☐ Yes, location? _____

Lameness or difficulty rising? ☐ No ☐ Yes, describe: _____

Any behavioral changes? ☐ No ☐ Yes, describe: _____

Has your pet chewed anything unusual recently? ☐ No ☐ Yes, if so describe: _____

If the doctor feels it is necessary, do you authorize:

☐ Bloodwork (\$82)

☐ X-Ray (\$75-125)

☐ Sedation (\$40-60)

If any external parasites are observed on your pet today, he/she will receive treatment at your expense.

Medical and/or Surgical Release:

I certify that I own the above described animal and I do hereby consent and authorize the St. Anna Veterinary Clinic to hospitalize my pet, administer vaccinations, medications, tests, surgical procedures, anesthetics, or treatments that the Doctors deem necessary for the health, safety or well-being of the above animal while it is under their care and supervision.

If my pet should injure itself, refuse food, soil itself, become ill or die while in the hospital, I will hold the St. Anna Veterinary Clinic, S.C., and staff free of any responsibility and/or liability in the absence of gross negligence.

Risks of routine surgery: blood loss, infection, reopening of the incision (dehiscence) and complications of anesthesia including death.

Other: _____

The nature of such service has been described to me to my satisfaction and I understand that some risks always exist with anesthesia and/or surgery, if this is what my pet needs. I am encouraged to discuss any concerns I have about those risks with my veterinarian before the procedure(s) are initiated. I realize neither the guarantee nor warranty can ethically or professionally be made regarding the results or cure.

____ I have received a written estimate and had the likely fees explained to me. I understand that there may be unforeseen complications and that further treatment may be necessary during hospitalization.

I accept and assume full and total financial responsibility for any and all services rendered by the clinic, its staff or employees in the treatment of the above described animal and agree to pay the fees at the time of my pet's discharge or other demise.

Hospital Policies

- 1. Accounts are payable in full at the time your pet is released from the Clinic. Cash, Checks, Credit Cards (Visa, MasterCard American Express), and Care Credit are accepted.**
- 2. I understand that if a friend or family member picks up my pet at discharge that I am required to send payment in full with that person.**
3. If your pet requires hospitalization the adult owner shall give written permission to the doctor to perform the necessary services.
4. Fees are for Current services only and do not include follow Up Care.

I have read the above Policy. By signing this form I agree to all of the above terms and conditions.

Owner signature _____ Date: _____

Phone Number for today _____

What time are you available to pick up your pet? _____

***Please keep in mind that we close at 4pm and payment is due at the time of service.*