



Admissions / Hospitalization Release

Date: _____ Owner's Name: _____

Pet's Name: _____

Contact number(s): _____

Reason for today's appointment? _____

(Please help us help your pet by filling out the below information completely.)

SYMPTOM(S)	Yes	No	IF YES PLEASE <u>CIRCLE</u> TO DESCRIBE *or write description on back*
Vomiting			white yellow pink brown food been in trash ate toy/string
Diarrhea			watery bloody cow pie mucous
Change in Eating			not eating at all not eating as much have offered treats recent diet change
Change in Drinking			drinking more drinking less not drinking at all
Change in Urination			bloody urine increased frequency increased amount not using litter box vocalizing
Coughing / Sneezing			moist dry pet tires easily occurs at night in daytime seasonal contact w/unknown animals
Limping / Lameness			right front right hind left front left hind sudden onset worsening same improving
Lumps / Lesions			Location (please show receptionist/mark on diagram) growing changed color changed texture

**HOW LONG SINCE THE ABOVE STARTED? _____

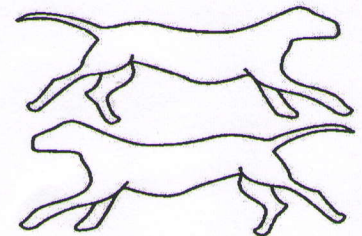
**HOW OFTEN IS IT OCCURRING? _____

**IF DIABETIC – Did your pet receive insulin this morning?: YES NO

If so, what brand? _____ How many units? _____ At what time? _____

**Did your pet eat this morning? YES NO

If yes, what time? _____ Did your pet eat a normal amount? YES NO [more | less



(Testing allows us to detect problems that are unable to be detected on physical exam)

****DIAGNOSTIC TREATMENT:** Digital Radiograph, Blood Work, and or other Diagnostic testing up to \$200.00

may need to be performed before communicating with clients. These tests are essential for proper diagnosing

and treating patient. (These service(s) do not include exam fees)

_____ client initial.

**** SEDATION:** May we sedate/anesthetize your pet if needed? (This amount does not include exam fee.)

YES: You may sedate my pet if needed.

NO: I do not want my pet sedated without being called first.

Additional Services requested Today: (Please mark appropriate box)

Ear Cleaning	
Nail Trim	
Fecal Parasite Exam	
Anal Sac Expression	

Avid Microchip	
Heartworm Test/Feline Felv/Fiv	
Feline Ear Mite Check	
Bath (healthy non-surgical pets only – cost by weight)	

Do you need refills of:

-heartworm prevention YES NO – if yes, how many? _____

-flea prevention YES NO – if yes, how many? _____

-prescription medications YES NO – if yes, Which Meds? _____

RELEASE: I hereby authorize Laketown Animal Hospital to perform the procedures as described above. I also authorize the hospital staff, in an emergency situation, to perform any additional procedures necessary for the well-being of my pet until further communication with me. I understand that I assume financial responsibility for all services provided and that no guarantee for successful treatment is made. Payment is due at discharge. I agree that follow-up examinations and additional treatment is not covered in today's price. Patients entering the hospital need to be current on vaccinations. Past due vaccination will be updated at my expense unless medically contraindicated. Suture removal is included in the surgery price. If I neglect to pick up my pet within two days of the pick up or release date and do not notify a hospital manager/supervisor within that time frame, LAH may assume that the pet is abandoned and are hereby authorized to dispose of as LAH deems best and/or necessary. (225 ILCS 115/18 IL Vet Med & Surgery Practice Act).

****By signing this form, you hereby agree to all of the previously mentioned statements and/or LAH policies**

****Signature of Owner/Responsible agent:** _____

Date: _____

ALL THE BELOW INFORMATION IS TO BE FILLED OUT BY LAH STAFF ONLY

Admitted by: _____

Carrier left with pet: yes no

Current on vaccinations: yes no (If not, may we update today?: yes no)

Meds left with pet: yes no (If yes, please list all meds.) _____