



MID-ATLANTIC
ANIMAL SPECIALTY
HOSPITAL



410.414.8250 (voice) • 410.414.2222 (fax)

410.535.9722 (voice) • 410.414.2222 (fax)

BRUCE S. NWADIKE, DVM, MRCVS, DACVS
RODNEY E. OAKLEY, DVM, DACVS
Surgery

BETH A. HUWE, DVM
ANIA LANGRALL, VMD
Emergency Medicine

PATIENT INTAKE FORM

Date: _____

Client Name: _____

Patient Name: _____

Contact phone numbers: 1. _____ 2. _____ 3. _____

DIETARY HISTORY

Was patient fasted overnight? Yes No Unsure

If so, what time was last feeding: _____ How much was your pet fed: _____

Is patient on special diet? Yes No If so, what diet? _____

Does patient have any known food allergies, or dietary restrictions? Yes No If so, what? _____

What kind of food does patient normally eat? Can Dry Mix

May we, if necessary, tempt patient to eat using the products we have in hospital? Yes No

MEDICATION HISTORY (additional room available if needed)

Has your pet had any previous drug, sedation, or anesthesia reaction? Yes No Unsure

<u>Name of Medication</u>	<u>Type of Reaction</u>

Is your pet on any medication? Yes No Unsure

<u>Name of Medication</u>	<u>Dose (mg or # of pills)</u>	<u>How often given</u>	<u>Quantity left</u>

Has your pet had any of the above medications today? Yes No Unsure

<u>Name of Medication</u>	<u>Time Last Given</u>

Have there been any changes in condition since patient was seen last? Yes No

If so, what? _____

OFFICE USE ONLY

Procedure being performed: _____

Blood work in file: Yes No

DISCHARGE CHECKLIST

- Discharge notes completed by veterinarian and reviewed by technician
- ID collar, IV Catheter and/or catheter bandage is removed *(if needs to stay in place, discuss care with owner)*
- Patient is in a clean state, not malodorous, and brushed as needed.
- Bandage/Incision is inspected for strike-through, changed if needed.
- Patient's belongings, including medication, have been taken from cubby area to be given to owner.
- Medications administration and times have been discussed with owner.

Tech initials _____



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MEDICATION HISTORY (continued)

Is your pet on any medication? Yes No Unsure

<u>Name of Medication</u>	<u>Dose (mg or # of pills)</u>	<u>How often given</u>	<u>Quantity left</u>

Has your pet had any of the above medications today? Yes No Unsure

<u>Name of Medication</u>	<u>Time Last Given</u>

Submit

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