Old Bridge Veterinary Hospital
3604 Old Bridge Rd
Woodbridge, VA 22192
Phone # (703) 494-0094
Email: obvhfrontdesk@gmail.com

Drop Off/Hospitalization Form

We care about your pets' health as much as we do yours. If you are showing any signs of illness or have been exposed to COVID-19, we ask that you stay home.

Please make sure your pet is on a leash or in a carrier upon arrival or we will not be able to take them from you.

PLEASE FILL OUT THIS FORM AND RETURN PRIOR TO YOUR SCHEDULED SURGERY DATE

CLIENT/PATIENT INFORMATION:

Owner's Name (First & Last) _____

Phone # at which we can reach you _____

E-Mail Address _____

Pets Name _____

Appointment Date:_____

REASON FOR APPOINTMENT:

☐ **Hospitalization** Pet's Current Symptoms: Please check all that apply.

☐ Coughing ☐ Sneezing ☐ Vomiting ☐ Diarrhea ☐ Bloody Diarrhea ☐ Unusual discharge

☐ Change in eating habits ☐ Change in drinking habits ☐ Change in activity level ☐ Lethargy

☐ Runny eyes/nose ☐ Skin Problems ☐ Dental problems ☐ Breathing problems

☐ Other: _____

_____

_____

_____

When were symptoms first noticed: _____

Duration of symptoms: _____

Does your pet take any medications? ☐ Yes ☐ No

If yes, medication name, strength, how much and how often?_____

_____

_____

I, _____, acknowledge that by leaving _____ at Old Bridge Veterinary Hospital, I am authorizing the veterinarian(s) and staff of Old Bridge Veterinary Hospital to continue with the steps (x-rays, blood work, etc.) necessary to diagnose and treat the problem(s) at hand.

I have read and understand the information above and understand that procedures will not be performed without proper authorization and signature of the pet's owner or responsible agent. Payment is expected when services are rendered; no billing or payment plans will be implemented unless prior arrangements have been made and approved by our office manager.

Signature of Owner: _____

Date: _____

☐ **Glucose Curve:**

Name of Insulin pet is taking: _____

Current Dose of Insulin: _____ Units A.M. _____ Units P.M.

Time of day insulin given on a regular basis: _____ A.M. _____ P.M.

Pet ate a meal today at (what time?): _____

Insulin was given at (what time?): _____

How is your pet doing? Any changes? (If yes please explain)

	NO	YES
Activity Level:	☐	☐ _____
Thirst:	☐	☐ _____
Appetite:	☐	☐ _____
Urination Output:	☐	☐ _____
Vomiting:	☐	☐ _____
Diarrhea:	☐	☐ _____

I hereby authorize the veterinarian(s) at Old Bridge Veterinary Hospital to perform a glucose check/curve and (+/-) urinalysis if necessary.

Signature of Owner: _____

Date: _____

☐ **ACTH Blood Test (Cushing's Disease Monitoring Blood Test)**

This blood test must be started between 4-6 hours after the pet takes medication.

Medication name, strength, how much and how often?_____

_____

_____

Time Medication was given today: _____

I have read and understand the information above and understand that procedures will not be performed without proper authorization and signature of the pet's owner or responsible agent. Payment is expected when services are rendered; no billing or payment plans will be implemented unless prior arrangements have been made and approved by our office manager.

Signature of Owner: _____

Date: _____

⬜ **Low Dose Dex Suppression Blood Test (Cushing's Diagnosing Blood Test)**

This blood test will take 8 hours to complete

I have read and understand the information above and understand that procedures will not be performed without proper authorization and signature of the pet's owner or responsible agent. Payment is expected when services are rendered; no billing or payment plans will be implemented unless prior arrangements have been made and approved by our office manager.

Signature of Owner: _____

Date: _____

⬜ **Ultrasound**

Pets having an ultrasound will need to be fasted overnight. Please pick up and/or remove any food left out for your pet by 9:00pm the night before. Water can be left out for pets to drink.
I understand and agree: (Initials _____)

If your pet is going to be sedated for the ultrasound please also fill out the **Sedation** portion of this form

I have read and understand the information above and understand that procedures will not be performed without proper authorization and signature of the pet's owner or responsible agent. Payment is expected when services are rendered; no billing or payment plans will be implemented unless prior arrangements have been made and approved by our office manager.

Signature of Owner: _____

Date: _____

⬜ **Sedation**

Reason for sedation appointment: _____

A complete physical exam will be performed on your pet prior to the surgical procedure. However, this may not identify all systemic or metabolic problems. For this reason, we require that your pet have pre-anesthetic bloodwork to evaluate major organ functions prior to anesthesia. This blood work consist of:

For pets under 8 yrs old, we require a PCV (pack cell volume) to check for anemia and Chem 10 to check for

kidney, liver and glucose levels.

For pets 8 yrs old and older, we require a CBC to check for anemia, infections and certain blood clotting problems and Chem 17 to check for kidney, liver, glucose and pancreas levels.

⬜ Blood work done (within 30 days) Date blood work was tested: _____

I understand that some risks always exist with anesthesia and/ or surgery and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before the procedure(s) is/are initiated.

Any concerns or questions regarding the sedation procedure? ⬜ Yes ⬜ No

If yes please explain: _____

_____

I understand that the attending veterinarian will make every effort to contact me regarding treatment in the case of unforeseen emergencies. If unable to contact me, the staff may or may not have my permission to proceed with life sustaining procedures.

I give my permission [Yes]: (Initials _____) I do not give my permission [No]: (Initials _____)

I also assume full responsibility for any additional expenses incurred after the procedure is performed, such as follow up radiographs, and re-check physical exams. These are more likely to occur when there is a failure to comply with the aftercare instructions.

Payment is expected when services are rendered; no billing or payment plans will be implemented without prior approval.

I have read and fully understand the terms and conditions set forth above and I authorize the Doctors of Old Bridge Veterinary Hospital to prescribe, treat and/or perform surgery as indicated above as well as any procedures deemed necessary for my animals' wellbeing.

Signature of Owner: _____

Date: _____