



Old Bridge Veterinary Hospital

3604 Old Bridge Rd

Woodbridge, VA 22192

Phone # (703) 494-0094

Email: [obvhfrontdesk@gmail.com](mailto:obvhfrontdesk@gmail.com)

## **Drop Off/Hospitalization Form**

**To help reduce the spread of COVID-19, clients will no longer be allowed in the facility.**

*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**

When you arrive, please call to check in. After check in, a member of our staff will escort your pet inside. If you have a dog, please wait outside of your vehicle with your leashed dog standing on the ground so our staff can safely apply one of our leashes and you may remove yours with as little human contact as possible. If you have a cat, we ask that you leave your cat in a secure carrier at the bottom of the stairs at the front entryway for our staff to bring inside safely with as little human contact as possible.

When you return to your scheduled discharge time, we ask that you call from the parking lot to let us know you are here. One of our doctors or technicians will discuss today's visit and any home care instructions over the phone and then meet you outside of your vehicle to safely return your dog, if you have a cat, they will be placed at the bottom of the stairs at the front entryway.

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.

### **CLIENT/PATIENT INFORMATION:**

Owner's Name (First & Last) \_\_\_\_\_

Phone # at which we can reach you \_\_\_\_\_

Emergency Contact Name and Phone # \_\_\_\_\_

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:	<input type="checkbox"/>	<input type="checkbox"/> _____
Thirst:	<input type="checkbox"/>	<input type="checkbox"/> _____
Appetite:	<input type="checkbox"/>	<input type="checkbox"/> _____
Urination Output:	<input type="checkbox"/>	<input type="checkbox"/> _____
Vomiting:	<input type="checkbox"/>	<input type="checkbox"/> _____
Diarrhea:	<input type="checkbox"/>	<input type="checkbox"/> _____

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 sedation procedure. However, this may not identify all systemic or metabolic problems. For this reason, it is strongly recommended that your pet have pre-anesthetic bloodwork to evaluate major organ functions prior to anesthesia if they are under 8 years of age.

Pre-anesthetic chemistry is required if they are 8 years of age or older.

Blood chemistry will measure BUN, Creatinine (kidneys), ALT, ALKP (liver), Glucose, and Total protein levels.

Pre-anesthetic Chemistry: ☐ Yes ☐ No (Only a choice for pets under 8 years of age)

☐ Blood work done (within 30 days) Date blood work was tested: \_\_\_\_\_

CBC will check for anemia, infections, and certain blood clotting problems (platelets).

Pre-anesthetic CBC: ☐ Yes (Optional) ☐ No

☐ 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: \_\_\_\_\_