HOSPITAL ADMISSION FORM

Client ID: _____      Patient Name:    _________________________________________     Date: ____

Items left: ☐ Leash  ☐ Collar  ☐ Carrier  ☐ Other_____________________

I authorize Park Veterinary Hospital to examine my pet and/or provide the following services:
☐ DA2PPV (canine distemper-parvo)  ☐ EXAMINATION  ☐ ULTRASOUND
☐ RABIES  ☐ HEARTWORM TEST  ☐ SEDATION
☐ BORDETELLA (kennel cough)  ☐ INTESTINAL PARASITE TEST  ☐ HOSPITALIZATION
☐ LEPTOSPORSIS  ☐ FELINE LEUKEMIA / AIDS TEST  ☐ CATHETER & FLUIDS
☐ LYME  ☐ WELLNESS BLOODWORK  ☐ PAIN MEDICATION
☐ PUREVAX RABIES (feline, 1yr)  ☐ EAR CYTOLOGY  ☐ LASER THERAPY
☐ FCVRP (feline distemper)  ☐ URINALYSIS  ☐ PEDICURE
☐ FeLV (feline leukemia)  ☐ FINE NEEDLE ASPIRATION  ☐ EXPRESS ANAL GLANDS
☐ OTHER: ____________________  ☐ RADIOGRAPHS (x-rays)  ☐ BATH
**PLEASE NOTE: We require an exam with vaccines.

**SIGN here to authorize SEDATION (if needed) WITHOUT contacting you.  _______________________________

MEDICAL HISTORY (Please COMPLETE these questions regarding your pet):
1. What do you feed your pet, how much, and how often? ______________________________________________

2. Have you noted any symptoms? (please note duration, frequency, and other details)
   ☐ Coughing  ☐ Sneezing  Describe: _________________________________
   ☐ Vomiting  ☐ Diarrhea  Describe: _________________________________
   ☐ Changes in Urination  Describe: _________________________________
   ☐ Changes in Eating/Drinking  Describe: __________________________
   ☐ Change in Activity level  Describe: _______________________________
   ☐ Other symptoms or concerns: ____________________________________

3. Please indicate all medications/supplements and monthly preventatives you give to
   _______________________________________________________________
   _______________________________________________________________
Heartworm Prevention: Unknown  Trifexis  Interceptor  Heartgard  Revolution
Flea/Tick Prevention: Unknown  NexGard  Vectra3D  Other: __________________

Refills needed?: (Y/N)  Which products and how much?: ______________________

CONTACT INFORMATION:
Please contact me after exam and authorized services: ☐ Yes  ☐ No
If I cannot be reached: ☐ I authorize testing and/or treatments up to a total of $_________.
☐ Do not perform further services until I can be reached. Best times to reach you: ______________________

I would like to pick up my pet at ________ on ________ and understand that payment is due at time of service.

Would you prefer: ☐ Call  ☐ Text  ☐ Email: _______________________________

_______________________ can be reached at ( ) ___________ ext.___  OR ( ) ___________
(NAME)

_______________________ can be reached at ( ) ___________ ext.___  OR ( ) ___________
(ALTERNATE NAME)

PRINT NAME: _____________________________      SIGNATURE: _____________________________

CHECKED IN BY: ________  TIME: ________