



Concordia Veterinary Clinic

2 NE Tenth Street, PO Box 153, Concordia, MO 64020
660-463-2332

Urgent Care and Hospitalization Authorization

OFFICE USE ONLY
Weight _____
When did pt. last eat/drink? _____
List ANY meds given this AM: _____
Vaccinations up to date? Y / N
Date _____
Pt. checked in by _____

Owner's Name: _____ Pet's Name: _____ Date _____

Name and Phone Number(s) of the decision maker who can be reached while your pet is at the clinic:

Please list the phone number of the person who needs to be contacted regarding decisions for care and updates. It is imperative that we can reach this person in a timely manner while your pet is at the clinic today. Please have the phone listed above available and be free to talk if needed. If you cannot be reached, it may result in slower diagnosis and delays in the treatment of your pet's condition.

Reason for your pets visit today _____

Please list any medications, supplements, topical treatments your pet has received in the past 72 hours and when they were last given _____

Does your pet have any chronic disease, health conditions, or had an allergic reaction in the past? Please circle **YES NO**
If yes, please describe _____

Pets entering the clinic who have external parasites (fleas/ticks) will be treated at the owner's expense.

Vaccinations: For the safety of all patients in the clinic,

ALL DOGS must have verifiable current status of Rabies and Parvo/Distemper immunizations.

ALL CATS must have verifiable current status of Rabies and Feline Distemper/Leukemia immunizations.

**If proof of vaccinations cannot be confirmed at the time of patient's admittance, vaccinations will be administered at the owner's expense when the veterinarian deems it is safe for your pet to receive them based on current health condition.*

Sedation: I authorize the use of appropriate sedation and pain relief medication as needed before or after the exam, procedure, or treatment. I understand that there are risks inherent in the use of sedatives and that there is no way to test for adverse reactions prior to this administration on a selected individual. Risks can include allergic reactions, disability, longer than normal recovery time, and death. Please circle **YES NO**

Cardiac Arrest: In the event of Cardiac Arrest would you like CPR performed on your pet? Please circle **YES NO**
Efforts may include Oxygen, Epinephrine, and Chest Compression. (Estimated cost is **\$25.00 - \$60.00**)

Additional Services

While your pet is in the clinic, would you like any of the following additional services? If nothing is marked, you are declining these tests or services.

- () Toe Nail Trim **COMPLIMENTARY** () Ear Cleaning **\$17.00** () Fecal Analysis **\$13.40** () Anal Glands **\$15.50**
- () Heartworm Test **\$13.00** () Feline Leukemia and Immunodeficiency Viruses Test **\$40.10**

Please list any additional treatments you would like to have done while your pet is here.

(Additional charges may apply.) _____

Payment for veterinary services is expected at the time services are provided or when the patient is released.

I hereby certify that I have read and fully understand this authorization for treatment. I am the owner or agent for the above listed animal and have the authority to execute this consent. I assume financial responsibility for all charges incurred to the above patient and agree to pay all charges when the animal is released from the clinic. I understand the Concordia Veterinary Clinic will use reasonable precautions to assure my animal's safety while it is in the clinic care, but I will not hold Concordia Veterinary Clinic responsible if my pet should injure itself, escape, fail to eat, become ill, or die. I authorize Concordia Veterinary Clinic doctors and staff to perform procedures and absolve the clinic and it's staff of all liability arising from the performance of procedures herein. I have reviewed the information and statements above and agree to these policies and procedures.

Signed _____

Date _____