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Medical Admittance Form

Owner's Name _____

Street Address _____ City _____ State _____ Zip _____

Admitted Pet's Name _____

My concerns about my pet include (please check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Ears (left, right or both) | <input type="checkbox"/> May have eaten toxin (such as _____) | <input type="checkbox"/> Lethargic (lack of energy) |
| <input type="checkbox"/> Eyes (left, right or both) | <input type="checkbox"/> Seizure | <input type="checkbox"/> Limping (which leg _____) |
| <input type="checkbox"/> Hair loss (location _____) | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pain (location _____) |
| <input type="checkbox"/> Itchy skin (location _____) | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Wound (location _____) |
| <input type="checkbox"/> Eating less than normal | <input type="checkbox"/> Straining to defecate | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Drinking more than normal | <input type="checkbox"/> Straining to urinate | _____ |
| <input type="checkbox"/> May have eaten foreign body (such as _____) | <input type="checkbox"/> Urinating more frequently | _____ |

Date and time problem was first noted: _____

The problem is: Getting worse Getting better About the same Recurring

My pet is on the following medications: _____

Please provide information you feel may be pertinent to your pet's condition (continue on the back of the paper if necessary):

Your pet will be examined by the first available doctor. The doctor will contact you by phone to discuss her recommendations. The exam is \$79.95 **with an additional \$30.00 urgent same day fee**. An estimate for diagnostic or treatment options will be presented to you once a doctor has done their exam. ***It is extremely important that the doctor be able to reach you or someone else able to make decisions for your pet by phone. If we cannot get a hold of you, please indicate the maximum dollar amount you are willing to spend.*** Please leave as many alternative contacts as possible (work, cell phone and pager numbers).

Phone number(s): _____

Companion Veterinary Hospital is dedicated to providing a Flea Free Environment. **If fleas are found on your pet we will administer parasite control. The charge for this treatment ranges from \$20-40, depending on your pet's weight.** Please inform us if you have used any flea preventatives within the last month.

Signature of Pet Owner/Agent _____ Date _____