



MAH Vista *Fast Paws* Admissions Form



Name _____ Date _____

Telephone number where you may be reached today: _____

Alternate contact person and telephone phone number _____

Preferred pick up date & time? _____

(Efforts are made to accommodate your needs – please call our office two hours after your drop off time to check on your pet’s status if a staff member has not contacted you: 760-758-8004.)

Pet: _____ **Species:** _____ **Breed:** _____ **Sex:** _____ **Color:** _____

History / Current medications: _____

Have medications been given today? Y / N If yes, list: _____

Any allergies to any vaccinations or medications? If yes, describe:

Current Diet: _____ How Much: _____ How Often: _____

Did your pet eat this morning? Y / N Regular diet / other: _____

Appetite: (circle one) Normal / Increased / Decreased / Other: _____

Does your pet get table foods? Y / N Food Allergies? On any nutritional or homeopathic supplements? Y / N
If yes, please list: _____

Is your pet current on vaccines that have been administered at a different location or clinic? Y / N If yes, where

If no, would you like us to update your pet’s vaccine status? Y / N

Is your pet on monthly heartworm prevention? Y / N Product: _____

Is your pet on monthly flea/tick prevention? Y / N Product: _____

Please check ANY symptoms or problems you have noticed about your pet:

- | | | |
|---|--|--|
| <input type="checkbox"/> Behavior Changes | <input type="checkbox"/> Discharges, explain _____ | <input type="checkbox"/> Head shaking |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Gagging | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Limping, which leg _____ | <input type="checkbox"/> Urination problem _____ |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Scooting | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Scratching | <input type="checkbox"/> Weakness | |

I would like the following services performed during your pet’s visit today:

- Nail trim
- Anal gland expression
- Ear wipe
- Bath
- Playtime Package
- Heartworm Testing

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT: As the owner or responsible party for the above patient, I authorize Mohnacky Animal Hospitals, Inc. to examine my pet and administer treatment, including medical procedures, administration of anesthesia, surgical procedures and diagnostic tests that in their judgment are consider reasonable and necessary. I understand that with any medical or surgical procedures there are always risks involved, including death, and that no warranty or guarantee is being made as to the results or cure. I assume full financial responsibility for all charges incurred and will pay in full for these services upon release of the patient. I have read and understand the above authorization for care and financial responsibility.

I understand that some pets require sedation/general anesthesia for adequate physical examination, treatment, or surgery. By signing below, I understand that there is risk involved when an animal is sedated.

Name Date

Employee Date
9/20

Cardiopulmonary Resuscitation Statement (Please Initial):

() DO NOT RESUSCITATE: In the event my pet's heart and/or breathing stop, I request no person shall attempt to resuscitate my pet.

() BASIC CARDIOPULMONARY RESUSCITATION:

I request the doctor(s) and staff attempt to resuscitate my pet through utilization of artificial respiration and/or heart compression, as well as administration of various emergency medications and/or fluids as deemed necessary and/or appropriate by the attending veterinarian. I understand that there is no guarantee in the success of these efforts and that my pet may die despite CPR.

I have read and understand the nature of the above procedures and give my consent to proceed.

Signature of Owner or Authorized Agent

Date