



Medicine, Surgery, And Rehabilitation Clinic P.A.

Day Admission Form Diagnostics

Patient Name: _____

Owner/Contact: _____ Preferred Contact Number: _____

(The doctor will use this number to contact you today, please make sure you are available) Text Call

Secondary Contact: _____ Secondary Contact Number: _____

Medical History – (Owner Complete)

Current Diet and Time of Last Meal: _____ **Pet Fasting?** Yes No

Current Medications & Time of Last Dose: (include over-the-counter, flea, tick, heartworm meds)

Has your pet been sick in the past week? (vomiting, diarrhea, coughing, lethargy)? Yes No If yes, please describe: _____

Do you have any concerns to be addressed during the visit today? Please describe in detail:

Diagnostic Tests – (Staff Use Only)

Glucose Curve / Fructosamine → Current Dose of Insulin _____ IU Time of last dose: _____

ACTH Stimulation Test → Addison's Suspected / Cushing's Suspected

→ Trilostane Monitoring Time of Last Dose: _____ **(4 hrs post pill)**

Low Dose Dexamethasone Suppression Test

Thyroid/T4 Test → Time of Last Dose: _____ **(draw should be 4 – 6 hrs post pill)**

CBC Chem 17 Chem 10 Electrolytes Urinalysis 4DX Bile Acids (fasting)

Radiographs → Thorax / Abdomen / Skull / Spine / Pelvis / Extremity: _____

Bandage change

Heartworm Treatment 1st Treatment 2/3rd Treatments

Other test not listed: _____

Optional Services: Nail Trim (\$38.95) Check ears (\$17.25) & treat if necessary (\$35-63)

Microchip Implant (\$70.00) Anal Gland Express (\$47.50)

I give my permission for All Pets to examine my pet today and perform any emergency procedures necessary to stabilize my pet in the case of an emergency.

*****If you DO NOT want us to perform life-saving measures before authorization, please initial:** _____

I understand that if my pet is found to have fleas they will be treated at my expense. _____

Signature: _____ Date: _____

Staff Initials: _____ Patient weight today: _____ Kennel number: _____ D/A Time: _____