6719 Lowell Avenue, McLean, VA 22101
Phone: 703-356-5582 Fax: 703-893-2441
E-mail: info @odahcenter.com
Website: www.odahcenter.com

# PROCEDURE & HOSPITALIZATION AUTHORIZATION

**PROCEDURE:** ☐ X-Rays ☐ Ultrasound ☐ Endoscopy ☐ Sedated Grooming ☐ Hospitalized

Other procedures / Doctor to examine – Notes: _____

| | Accept | Decline |
|---|---|---|
| Scheduled for Doctor: _____ | | |
| Authorize sedation/anesthesia if Dr. feels necessary | ☐ | ☐ |
| Use IV fluids if Dr. feels advisable | ☐ | ☐ |

**MEDICAL UPDATES/SPECIAL REQUESTS:**

Update heartworm and/or fecal if due – Notes: _____

Vaccines will be given if due at Dr. discretion – Notes: _____

Other requests: _____

**LAB SAFETY:** ☐ Completed ☐ Dr to run appropriate tests if necessary

**MEDICATIONS:** 1) _____last given_____2) _____last given_____

**FEEDING NOTES**: _____

**BEDDING AND KENNEL ITEMS: (initial preference)**

Initial

**YES,** my pet can have ODAH Center provided bedding or personal items left with him/her in their kennel. ODAH Center will not be held liable for any injury, illness, or loss that may occur during the boarding period, including but not limited to, loss of personal items, damage to property, injury, illness or death to my dog or other animals due to bedding, clothing, toys, etc.

**ITEMS LEFT:**_____
_____
_____

Initial

**NO** bedding, toys or clothing should be placed in the kennel with my pet(s).

**MEDICAL EMERGENCY AUTHORIZATION:**

Initial

I am the owner/authorized agent of the animal described below and authorize Old Dominion Animal Health Center (ODAH Center) to provide services as necessary to preserve the pet's life and well-being, and I absolve and release ODAH Center from any loss, expense, or liability arising from the performance of these services. In the event of a medical emergency, outside of regular hours, ODAH Center may transport the pet to a 24-hour emergency clinic, and I authorize ODAH Center staff members to grant permission for diagnostics and treatment at that facility until I am able to be contacted. All fees incurred at that 24-hour emergency clinic and/or ODAH Center, as well as all liabilities or losses are the sole responsibility of the owner or agent. I understand that the center is closed and not medically staffed outside of regular business hours.

*** I ALSO ACCEPT THAT ANY MEDICAL CONDITION WE BELIEVE TO BE PUTTING THIS PET IN PAIN OR RISK, INCLUDING INTESTINAL UPSET WILL BE TREATED IMMEDIATELY AT REGULAR HOSPITAL FEES.**

**VACCINATIONS AND PARASITE PREVENTION AUTHORIZATION:**

Initial

I understand that my pet(s) must be current on all required vaccination and be free of fleas and intestinal parasites. I authorize my pet to be vaccinated and treated for fleas and/or intestinal parasites if necessary.

**FINACIAL AUTHORIZATION:**

Initial

I accept all financial responsibility for the above services, including any emergency clinic fees, and understand that, unless agreed to in advance, these fees must be paid before the pet is released. I also accept that all boarding charges accrue per calendar day. All credit card payments will receive a 3% transaction fee. Debit cards, checks and cash are excluded from this fee.

**MULTIPLE PET FAMILY:**

Initial

I authorize and instruct ODAH Center to board my pets together in the same space. I absolve ODAH Center from any liability for injury or illness that may occur as a result of this action.

**ADVANCE MEDICAL AUTHOIRZATION:**

Initial

If my pet becomes critically ill and I am unavailable, I have an Advance medical Authorization form on file.

**ANESTHESIA & SEDATION AUTHORIZATION**

Initial

I am the owner/authorized agent of the animal and authorize ODAH Center to perform sedation and anesthetic and perform sedation/anesthesia and the procedure described on my pet. I have been informed of the nature of this procedure and the associated risks. I understand that no anesthesia or surgical event is completely without risk, and that in the event of any complications, I authorize the necessary treatment and care to respond to such complications and understand that I am responsible for any additional costs for that treatment.

I need an estimate/management to call before proceeding Yes No

Print Name_____Pet's Name_____

Phone-Day_____Night_____Cell_____

If I cannot be reached call_____Phone_____

Date_____Signature_____

**Admitting Staff Initials**_____Pick-Up Appt Scheduled Date_____Time_____Dr._____

# PROCEDURE/HOSPITALIZATON AUTHORIZATION

Old Dominion Animal Health Center 6719 Lowell Ave. McLean, VA 22101