Rowland Animal Clinic

2314 Plainfield Road Crest Hill, IL 60403 815-729-1111

DROP OFF/HOSPITALIZATION CONSENT FORM

Client Name: _____ Pet's Name _____

	YES	NO	Date Started
Vomiting/# times			
Diarrhea			
Coughing			
Sneezing			
Loss of Appetite			
Straining to Urinate			
Blood in Urine			
Lethargy			
Increased Thirst			
Increased Urine			

Other Signs:_____

Does Dr. Rowland have permission to run diagnostic tests (bloodwork, urinalysis, fecal):

YES _____ NO _____

Does Dr. Rowland have permission to run X-rays:

YES_____ NO _____

Does Dr. Rowland Have permission to administer basic medical treatment (fluids, injectable medication, oral medications) YES _____ No _____

CONSENT FOR ADMISSION TO HOSPITAL

I am the owner or agent for the owner of the animal described on this form, and have the authority to execute this consent. I request that Dr. Rowland, of Rowland Animal Clinic perform the services which are necessary to the examination, medication and treatment of the animal specifically identified on this form. I authorize Dr. Rowland (and the assistants he designates) to examine the animal and to administer medical treatment which is considered therapeutically and/or diagnostically necessary on the basis of the findings during the course of the examination. Therefore, I hereby consent to and authorize the performance of such procedure(s) as are necessary according to Dr. Rowland's professional judgement. I further understand that any animal found to be infected with either external or internal parasites will be treated for same, at my expense. I understand that the treatment of the patient will be conducted with due care and in accordance with the prevailing standards of competency in Veterinary Medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by Dr. Rowland, or the employees of Rowland Animal Clinic. I assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon discharge.

Signature: _____ Date: _____

Daytime Contact Phone: _____ Other Contact Phone: _____

Email: _____