

**Pet Care Associates**  
**5250 Hog Mountain Road**  
**Flowery Branch, GA 30542**

Drop Off / Hospitalization Form

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Pet Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ or (\_\_\_\_) \_\_\_\_\_

Preferred doctor: \_\_\_\_\_ Pick Up time requested: \_\_\_\_\_

**Current Vaccinations are required for Treatments (drop-offs or hospitalization).** If vaccinations are unable to be verified, your pet will receive all required vaccines at your expense.

**Primary Complaints:** \_\_\_\_\_ Coughing \_\_\_\_\_ Sneezing \_\_\_\_\_ Vomiting \_\_\_\_\_ Diarrhea  
\_\_\_\_\_ Lethargic \_\_\_\_\_ Not Eating \_\_\_\_\_ Not Drinking \_\_\_\_\_ Excessive thirst \_\_\_\_\_ Urinating issues

List any problems your pet has had. Including description of severity and duration:

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It is necessary for surgical patients, some treatment patients, and very aggressive patients to receive a sedative or anesthetic. Pet Care Associates \_\_\_\_\_ (does) **OR** \_\_\_\_\_ (does not) have permission to give my pet a sedative or anesthetic agent. Aggressive unmanageable patients will incur additional handling charges.

As with any sedative or anesthetic administration risks are involved, even death. It is recommended for your pet's safety that all patients have blood values evaluated prior to sedation or anesthesia. Pet Care Associates (does) \_\_\_\_\_ **OR** (does not) \_\_\_\_\_ have permission to run this bloodwork.

Pet Care promotes a flea/tick-free environment. If fleas or ticks are noted on the initial exam of patients admitted to the hospital, products will be used to eliminate these parasites. Also if the patient is staying in our facility and is not on a heartworm preventative, Pet Care Associates reserves the right to check for and/or treat for intestinal parasites. These treatments will be at the Client's expense.

**I am the owner of the above listed animal and I assume all financial responsibility for all charges incurred in the care of this animal(s). I do hereby agree to all the above terms and understand fully, the requirements listed above. I understand that payment is due at the time services are rendered.**

OWNER SIGNATURE \_\_\_\_\_

Emergency Contact Number \_\_\_\_\_