



Louisburg Veterinary Hospital

Patient Drop-Off Form

In an effort to ensure we communicate examination findings, treatment recommendations and obtain authorization for services from the responsible party for your pet's care, please complete the information below.

Responsible Party

_____ I am the responsible party for decisions and payment. My best contact information is listed below.

_____ I am NOT the responsible party. The best contact information for the responsible party is listed below.

Client & Patient Information

Client Name		Patient Name	
Best Contact Number		Date	
Preferred Contact (circle)	Text / Call		

Being responsible for the above-described animal, I have the authority to grant consent to receive, prescribe for, treat and/or operate on my pet.

Treatment Authorizations

_____ Perform bloodwork as recommended for my pet (estimated cost \$308)

_____ Decline recommended bloodwork

_____ Give medication in the hospital and prescribe medication for home use if needed

_____ Decline medication authorization

_____ Use fluid therapy if needed as determined by the doctor

_____ Decline fluid therapy

_____ Update annual vaccinations or recommended diagnostic testing

_____ Decline vaccines or diagnostic testing

Feeding Information

What do you feed your pet and when was he/she last fed?

Reason for Visit / Concerns

Please list the reasons for today's visit and any concerns you may have.

Current Medications

List any medications your pet is currently taking.

Additional Concerns

Are there any additional concerns you would like us to address during this visit?

Hospital Policies & Acknowledgements

I understand that Louisburg Veterinary Hospital is not staffed overnight and I accept any risks incurred by leaving my animal overnight unattended.

I understand a written estimate for services will be made available upon my request and I will provide a 50% deposit for estimated fees.

If fleas are found on my pet, I authorize treatment with an appropriate flea preventative and understand I will be charged.

I understand Louisburg Veterinary Hospital is not responsible for personal belongings left with my pet.

I understand no guarantee has been made regarding results and I assume financial responsibility for services rendered.

CPR Consent Directive

If your pet requires cardiopulmonary resuscitation (CPR), please indicate your wishes below. A minimum CPR fee of \$190 may apply if resuscitation efforts are performed.

_____ REQUEST CPR for my pet if medically indicated

_____ DECLINE CPR (Do Not Resuscitate)

Owner / Responsible Party		Phone Number	
Signature		Date	

Louisburg Veterinary Hospital

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Call or Text: (919) 496-2638 • Fax: (919) 496-2699

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