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

☐ **HOSPITAL BOARDING INSTRUCTIONS** ☐ **SPECIAL NEEDS HOSPITAL BOARDING INSTRUCTIONS**

I will pick up on: Date_____Time_____

Or ☐ I will call with pick up date.

I can be reached at _____ Or_____

If I cannot be reached there, call: _____

May we send brief text messages? Yes / No (Please circle) Preferred cell number for texts:_____

Are you available by email? If so, please provide email address:_____

DIABETIC PETS:

All diabetic pets will have a blood glucose test done upon check-in and check-out.
Type of insulin: _____ When was insulin given last: _____
Number of units: _____per dose Location of injection site: _____
Time(s) of day: _____ Time pet last ate:_____

FEEDING INSTRUCTIONS: ☐ Own food ☐ Dry Only ☐ Canned Only ☐ Canned & Dry
Number of feedings per day: _____ How much per feeding: _____

MEDICATIONS TO GIVE:

1) _____ next dose due_____
2) _____ next dose due_____
3) _____ next dose due_____
4) _____ next dose due_____
5) Follow-up Acupuncture _____ next treatment due_____

MEDICAL SERVICES REQUESTED (VACCINES WITH AN ASTERISK REQUIRE A PHYSICAL EXAM)

☐ Update **required** vaccines, annual test and exam:
Canine (*Rabies, *DaP or *DHPP, *Leptospirosis, Bordetella, H3N8 CIV and Fecal test)
Feline (*Rabies, *HCP or *FVRCP)

☐ Please also update all **recommended** vaccines, annual test and exam:
Canine **(***Lyme vaccine, H3N2 CIV vaccine and Heartworm test) ***Feline*** (Fecal test and *Feleuk vaccine)

☐ Check medical and vaccine history at:
Name of Clinic: _____ Location:_____
☐ Request doctor_____to examine (We may need to substitute a doctor)
☐ Dr. may examine and treat as necessary, if a medical issue arises ☐ ODAHC should call before exam and treatment

PLEASE COMPLETE OPPOSITE SIDE

MEDICAL PROBLEMS WE SHOULD BE AWARE OF:

_____

_____

BEHAVIORAL OR PHYSICAL LIMITATIONS WE SHOULD BE AWARE OF:

_____

_____

MEDICAL TREATMENTS OR SERVICES NEEDED: (Additional fees may apply)

_____

_____

☐ Special walk/exercise assistance_____ ☐ Hand feeding

☐ Other _____ ☐ Massage (Subject to masseuse availability: discuss with staff.)

☐ Extra walk at 8pm ☐ Nail trim ☐ Dremel nails ☐ Daily brushing ☐ Laser Therapy ☐ Physical rehabilitation
☐ Daily tooth brushing ☐ Special ODAHC treat after PM walk ☐ Daily Pup-Sicle

CAPITOL CANINE CLUB: (Additional Fees Apply)

☐ Behavioral evaluation ☐ Daily play group (Mon-Sat)

☐ Selected days (during entire stay) **Mon. Tue. Wed. Thur. Fri. Sat.**

☐ Selected days (specify dates) _____

BATHING INSTRUCTIONS:

☐ Bath (includes nails and ears) ☐ Professional Grooming (by appointment only) ☐ Moisturizer ☐ Clip mats

☐ Tooth brushing ☐ Dr/Tech to express anal glands ☐ Dremel nails (Dremel trim not included in bath)

Do you need an estimate for additional services not included in daily boarding fee? YES NO

_____

I am the owner of the animal described below and authorize Old Dominion Animal Health Center (ODAHCenter) to provide services as necessary to preserve the pet's life and well-being, and I absolve and release ODAHCenter from any loss, expense, or liability arising from the performance of these services.

I also understand that the animal must be current on all vaccinations and parasite checks. I authorize the animal to be vaccinated, and/or bathed if necessary, and that these services will be charged at the regular hospital fees. I understand that the center is closed and not medically staffed outside of regular business hours, except by appointment or in an emergency; however, an experienced staff member lives on the premises and staff is present for cleaning, feeding, and exercising 24 hours a day.

I accept all financial responsibility for the above services and understand that, unless agreed to in advance, these fees must be paid before my pet is released.

AUTHORIZATION:

Initials

*** 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.**
*** BOARDING CHARGES ACCRUE BY CALENDAR DAY.**
*** ODAHC IS NOT RESPONSIBLE FOR THE LOSS OR DESTRUCTION OF ANY ITEMS LEFT WITH THE PET.**

Print pet's name: _____ Print Owner's Name:_____

Signature: _____ Date: _____

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

Initials:_____

***Admitting Staff Member*_____**