

CLIENT INFORMATION SHEET

www.kinder4rescue.org

Send Records and Xrays to – xrays@kinder4rescue.org

Client Information

Microchip# _____ Need Microchip

Owner's name: _____

Driver License #: _____

Driver License State: _____

Date of Birth: ____/____/____

CONTROLLED SUBSTANCE REQUIREMENT

Check box for which number we can reach you at today:

Phone: (Home): _____ (Cell): _____ (Work): _____

Email: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Spouse/Other: _____ Phone (Cell): _____

In case of Emergency, call: _____ Alt: (_____) _____

Method of Payment: Cash Credit Card Scratchpay.com Venmo Other: _____

How did you hear about us? _____

Pet Information

Pet's Name _____ Species: Canine/Feline Breed: _____

Color: _____ Age: _____

Female Spayed/Castrada - Yes No

Male Neutered/Castrado - Yes No

How many other pets do you have at your house? _____ Female Spayed/Castrada - Yes No Species: Cat / Dog
Male Neutered/Castrado - Yes No Species: Cat / Dog

Previous/Current Vet: _____

Does your company have a matching donation program?

Yes

No

I am the owner (or authorized agent for the owner) of this pet and over 18 years of age. The information given above is correct. I understand every effort will be made to achieve a successful outcome and to provide for all possible safety Clinic Care and handling. I hereby authorize this clinic to receive, prescribed for, and treat the pet(s) listed above. Furthermore, I agree to pay fees for all services rendered at the time the pet is discharged from the clinic. I understand I am responsible for payment and agree to pay the reasonable costs of collection, attorney fees, and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the clinic is located. I also authorize *Kinder4Rescue Low Cost Vet Clinic* to release or transfer my pet's medical records to another Veterinary and/or Boarding Facility. Please notify Kinder4Rescue if Payment Assistance is needed prior to services. A list of foundations that assist in medical care can be provided for pre-approval.

Signature: _____

Date: _____

Patient History

Date: _____
Pet Owner's Name: _____
Pet's Name: _____

Species: Dog Cat Other _____
Sex: *Intact* Male *Neutered* Male
 Intact Female *Spayed* Female

! Reason for visit: _____

Date of Injury: _____

How did the injury occur? _____

Do you have recent records? Yes No **Sent:** Yes No

Email: xrays@kinder4rescue.org **Fax:** 1 (818)-505-0026

HAS YOUR PET...

- | | | | |
|--|------------------------------|-----------------------------|---------------------------------|
| 1. Annual vaccinations within the last year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 2. Rabies vaccination current? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 3. Any recent surgery or dentistry? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 4. Any illness or injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 5. Medication or a current medical problem? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |

If YES, _____

- | | | | |
|--|------------------------------|-----------------------------|---------------------------------|
| 6. Any recent physical examination within the last year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 7. Any recent bloodwork, x-rays, ECG, other? (Circle) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 8. Exposure to any animal with an unknown illness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 9. A recent pregnancy or heat period? (Circle) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 10. When was the last time your pet ate? Date: _____ | | Time: _____ | |
| Drinking more or excessive water intake? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |

HAVE YOU NOTICED ANY...

- | | | | |
|---|------------------------------|-----------------------------|---------------------------------|
| 1. Coughing, sneezing, shortness of breath, or tiring easily? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 2. Change in appetite or eating habits/weight loss? (Circle) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 3. Recent vomiting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |

If YES, when did it start? _____ Color of vomit: _____

- | | | | |
|---|------------------------------|-----------------------------|---------------------------------|
| 4. Recent diarrhea? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| If YES, when did it start? _____ Blood in stool: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 5. Blood in urine, or other discharge? (Circle) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 6. Unusual attitude, fainting, or seizure? (Circle) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |
| 7. Swelling, limping, or pain in moving? (Circle) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unsure |

8. Is your pet unable to urinate? **Yes**- spot peeing. **No**- Not urinating. Color of urine: _____

If YES, when did it start? _____

How closely is your pet observed? _____

Other Info: _____





Kinder4Rescue

14926 Vineland Ave N. Hollywood 91601 # (818) 505-0006

Surgery Release

Pet Name: _____ Species: _____ Breed: _____

Color: _____ Pet's Age: _____

Female Spayed/Esterilización - Yes No Male Neutered/Castración - Yes No

Previous/ Current Vet: _____

Carefully read and understand the following before signing your name:

- I, acting as owner or agent of the pet named above, hereby request and authorize Kinder4Rescue, through whomever veterinarians they have designate, to perform an operation of the animal named on the above
- portion of this form.
- I understand that the operation presents some hazards and that injury to or death of such an animal may conceivably result, for there is some risk in the procedure and the use of anesthetics and drugs in providing this service. I certify that my animal is in good health and has had no food since midnight prior to surgery (if older than 4 months).
- I understand that Kinder4Rescue has the right to refuse service to any animal to whom surgery is deemed a health risk.
- I understand that my animal will receive pre-operative bloodwork at owner's expense.
- I understand some factors significantly increase surgical risk, including but not limited to, pregnancy, heat, and diseases such as feline immunodeficiency viral infection, feline leukemia viral infection, and heartworms.
- I understand that the **Blood Draw Fee is \$89** for clients **who will be using** our facility for surgery.
- I understand that if my pet **will not be** using the facility for surgery, than the blood work will be an **additional fee of \$61; totaling \$150.**
- I understand that blood results will not be released until the correct fee is paid.

- **I understand that if any anesthetic procedure is performed on my animal, the veterinarian will choose to also spay or neuter them at a cost to the client.**
- **I understand that all teeth to be pulled will be done at the discretion of the doctor in the interest of the health of my pet.**
- **If you do not show up to pick up your pet, you will be charged \$300 for an overnight fee.**
- **Brachycephalics carry a huge risk when it comes to anesthesia and treatments for your pet. The most common issue is overheating and trouble breathing due to their abnormal anatomy. Although, we take precautions, this higher anesthesia risk can result in death to your pet, I understand the additional risk to my pet, I agree to proceed. In addition,**
I agree not to hold Kinder4Rescue or our veterinarian staff responsible.

Initials: _____

I hereby release Kinder4Rescue, Kinder4Rescue Pet Clinic, all veterinarians, assistants, volunteers, directors, and employees from any and all claims arising out of or connected with the performance of this procedure or any adverse reactions to vaccinations or medications. I agree that I have not and will not claim any right to compensation from them, or any of them, or file any action by reason of such surgery of such animal or any consequences related thereto. Owner/agent hereby agrees to indemnify and hold Kinder4Rescue harmless for any damages caused during by any unforeseeable events including fire, vandalism, burglary, extreme weather, natural disasters, or acts of God.

Signature: _____ Date: _____

TO BE COMPLETED BY CLINIC ONLY

Orders:

1. _____

2. _____

3. _____

4. _____

5. _____

TO BE COMPLETED BY CLINIC ONLY

Notes:

Physical Exam		Date: _____	
Weight _____		Attitude _____ BCS _____ / 9	
	Normal	Abnormal	Remarks
Hydration	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	<input type="checkbox"/>	
Nose	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth	<input type="checkbox"/>	<input type="checkbox"/>	
PLNs	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Neuro	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Left front	<input type="checkbox"/>	<input type="checkbox"/>	
Right front	<input type="checkbox"/>	<input type="checkbox"/>	
Left hind	<input type="checkbox"/>	<input type="checkbox"/>	
Right hind	<input type="checkbox"/>	<input type="checkbox"/>	

TO BE COMPLETED BY CLINIC ONLY

Doctor's Notes: _____

Assessment: _____

Bloodwork: _____

XRays: ABD: _____ CHEST: _____

OTHER: _____

Recommendation/Refer to: _____

Surgery: _____


Patient Information – CLIENTS TO COMPLETE BELOW

Pet's Name: _____

Owners Name: _____

Breed: _____ Color: _____

Age: _____ Sex: M / F Spayed/Neutered: Y / N



Kinder4Rescue
 LowCost Pet Clinic&AdoptionCenter
 4926VinelandAve, NorthHollywood, CA91601
 Office: (818)505-0006

FINANCIAL INVOICE

Prev BW date _____ BW 125 150 89

Voucher: Done Received **XR** 150 75

Anesthesia _____

Biopsy 150 300 Decline

Pain Inj. | Meds Overnight _____ /

Deposit **Rebate** -

Balance: \$ _____ **PD Total:** \$ _____

PB Credit | Debit (2.6%) Venmo ScratchPay

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