Client Last Name: _____ _____ Chart # _____

Weekly Home Exercise Report	
Name	
Please record the therapeutic modalities that you have been practicing at home with the following format: reps or duration, times per day or week	
Heat therapy	
Cold therapy	
Passive range of motion	
Gentle massage (effleurage)	
Sit to stand exercises	
Walking flat ground	
Walking uphill	
Walking downhill	
Stairs	
Slow jogging	
Ball play	
Please note current medications and any changes:	
Have you noticed any improvement or decline in your dog's ability or stamina?	
Any other pertinent concerns?	

Client Instructions for Rehabilitation Drop Off Patients:

It is recommended that your pet be fasted prior to your rehabilitation appointment. This will keep them motivated and happy throughout their therapeutic appointment as we utilize treats to facilitate necessary behaviors for rehabilitation. If your pet is not motivated by treats, please consider bringing any toys, noisemakers or other ideas you have that may be of use to make your pet more comfortable.

If your pet has any food allergies that we should be aware of please list them here:

If you would like, you are welcome to drop off your pet's breakfast, as well as his or her favorite treats or toys for us to use during the session. If there is any breakfast left over following treatments, we will be happy to feed the remainder of breakfast after the exercises are complete. If you have brought such items, please list them here so that we can be sure that any remaining items are returned to you at the end of the session:

Please let us know if there are any changes at home since your last visit that you would like us to be aware of:

Morena Pet Hospital and Bird Center

1540 Morena Blvd. San Diego, CA 92110·(619) 275-0888

Consent Form

Please read the following consent statements so that you fully understand what you are authorizing us to do.

I consent to admit my pet to Morena Pet Hospital *and authorize the doctors and staff to perform procedures that are considered necessary by the attending doctor. The nature of the procedure has been explained to me and I understand why it is recommended and/or necessary.*
Please Initial_____

FOR PETS UNDERGOING ANESTHETIC PROCEDURES:
I am aware that there are inherent risks involved and inherent dangers present in all procedures that require anesthesia. This includes, but is not limited to: post-surgical infection, pain, and/or anesthetic reactions. I understand the advantages and possible complications of the procedure and acknowledge that no guarantees or advances have been made as to the results that may be obtained. ***Please Initial***_____

I hereby consent the attending veterinarians and their designees to perform the following procedures:

_____Spay _____Neuter _____Dental _____Mass Removal
_____Radiographs (XRAYS) _____Bloodwork
Other (please specify):_____

Any pets that are flea laden will be given a Capstar tablet. This is an additional $10.00 and is done in order to minimize fleas in our hospital. Please Initial _____

Please indicate below your preference regarding the treatment options and costs **(check one):**
___Please perform any necessary diagnostics and treatments indicated for the care of my pet until someone may be reached, up to $_____
___Do not administer any treatments until specific authorization is given
Note
If we are unable to reach you in the event of an emergency regarding your pet's health, be advised that whatever measures are deemed necessary will be taken to ensure your pet's health. You will be responsible for charges incurred within these measures.

****

I hereby certify that I have read and fully understood the proceeding consent form. I agree to financial responsibility and understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.
Please call after 3pm to receive an update on your pet and to arrange a pick up time. Discharges are typically between 4-6pm.

Please list a phone number where you can be reached today:_____
In the event that we are unable to reach you, please list an alternate contact person and phone number who will be able to authorize treatment recommendations:_____

Signature of owner or authorized agent:

_____ ***Date:***_____