Roseworthy Veterinary Hospital

DATE:

CHECKLIST FOR ADMITTING PATIENTS INTO THE RVH

Patient: **Patient ID:**
Owner: **Tel:**

QUESTIONS

Admission Nurse : _____
Travel time to RVH today: _____
Does the horse live at the address listed above? ☐ Yes ☐ No, residing at_____
When was the patient last vaccinated? Tetanus: 2in1: Strangles: Tetanus Anti-Tox:
Hendra: Other:.....

1. Has your pet resided or visited NSW or QLD in the past 30 days? ☐ Yes ☐ No _____
2a. If yes to the above question, is your horse vaccinated against Hendra Virus? ☐ Yes ☐ No
If NO to the above question, contact the Specialist Medicine Clinician on Duty, and do NOT admit the patient (Clinician will confirm admission under the Hendra Protocol)

2b. If yes to 2 (A), have you confirmed this via the Hendra virus register? ☐ Yes ☐ No

General demeanour last 24hrs? ☐ Normal ☐ Abnormal _____

Coughing? ☐ Yes ☐ No Nasal discharge? ☐ Yes ☐ No

Abnormal temp? ☐ Yes ☐ No Diarrhoea? ☐ Yes ☐ No

Is your animal currently on any medication: ☐ Yes _____ ☐ No

Does your animal have any behavioural issues/stable vices we should be aware of?(ie: Head shy, bites, kicks, etc) ☐ Yes ☐ No If Yes .....

Would you class your pet as suitable for all levels of handlers to work with? ☐ Yes ☐ No

If No, which level of handler is required: ☐ Beginner ☐ Intermediate ☐ Experienced

Do you give the RVH permission to send your referring Veterinarian any medical records from today's visit? ☐ Yes ☐ No

ASSESSMENT IN TRANSPORTATION AT RECEPTION

General Demeanour:	☐ BAR ☐ QAR ☐ Dull	Faecal Consistency: ☐ None ☐ Normal ☐ Dry and Bally ☐ Soft	☐ Semi-formed ☐ Cow Pat ☐ Diarrhoea ☐ Watery Diarrhoea
Nasal Discharge:	☐ Yes ☐ No Colour: Consistency:	Pharyngeal Swelling:	☐ Yes ☐ No

ASSESSMENT ONCE PATIENT IS IN DESIGNATED UNLOADING AREA

Does the patient have a microchip: ☐ Yes ☐ No Microchip Number:
Temperature taken: ☐ Yes ☐ No Reading: _____ Body weight (kg): _____

IF ANY ABNORMALITIES OR CONCERNS AT ANY POINT OF ADMISSION, SEEK VETERINARY ADVICE IMMEDIATELY

Roseworthy Veterinary Hospital

PATIENT TEMPERAMENT BEHAVIOUR ASSESSMENT FORM

Client:

DATE OF ADMISSION:

Patient:

Green	**Write your notes in here**
Yellow	**Write your notes in here**
Red	**Write your notes in here**

Roseworthy Veterinary Hospital

Outpatient Procedure Consent Form

PART A – Owner and Patient Information			
Patient Name:		**Owner Name:**	
Patient ID:		**Client ID:**	
Species:		**Telephone:**	
Breed:		**Animal ID** Microchip/tag/branding	
Sex:		**Weight:**	
Age:		**PIC #:**	

➤ **PART B – Patient Condition at time of admission** - When did the patient last?		
Eat or have access to food?		
Drink or have access to water?		
a. Does the patient have access to any toxins?	☐ Yes ☐ No If yes please state	
b. Has the patient been unwell in the past week?	☐ Yes ☐ No If yes please state	
c. Does the patient have any known drug / anaesthetic reactions?	☐ Yes ☐ No If yes please state	
d. Current medications or supplements:	☐ Yes ☐ No if yes please list below	
List of medications or supplements	**Frequency**	**Dosage**
1.		
2.		
3.		

PART C - Consent to treatment & procedures	
1.	➤ I give consent for the provision of Treatment and Procedures specified below for the patient:
2.	I acknowledge that the Treatment and Procedures, and thus cost estimates, may need to vary in response to changes in the animal's condition or results of diagnostic testing.
3.	I acknowledge that the risks (if applicable) of the course of action described have been explained to me and confirm that I understand and accept those risks.
4.	I have had the opportunity to discuss the Patient's treatment and course of action recommended by RVH as detailed in this Form. I understand the choices available to me, and I consent to the treatment and procedures so described being carried out on the Patient.
5.	I consent to Further Procedures and Treatments being provided, and to the associated costs, in the event that RVH is unable to contact me prior to further delay becoming detrimental to the patients health. Further Treatment and Procedures may include, but are not limited to the provision of CPR, surgical, diagnostic and therapeutic interventions deemed necessary or advisable by RVH since admission.
6.	I acknowledge that the following procedures may result in unusual or exceptional complications and out comes which include, but are not limited to the following risks which I also understand and accept: · Sedation/Anaesthetic risk: cardiac arrhythmias, myopathy, neuropathy, fracture of limb, trauma or abrasions on recovery, some of which may result in death

	· All drugs, sedatives, anaesthetics, surgery and other procedures involve some risk of allergies, anaphylaxis and a potentially fatal outcome. The RVH aims to minimise these risks by including any of the following in the patients procedure as required: fluid therapy, pain management, electronic monitoring, gas anaesthesia and trained veterinary staff for induction, surgical monitoring and recovery.
7.	I acknowledge and agree that, to the fullest extent permitted by law, the University of Adelaide, RVH, and their employees, students, agents, contractors, and successors (together, "RVH") have no liability to me for, and I release RVH from all liability in respect of, any death, injury, disability, illness, loss, or damage suffered or sustained by the Patient arising out of or in connection with either the treatment and procedures administered to them by RVH or any direction, act or omission on the part of RVH, except to the extent that such liability arises from the gross negligence, wilful misconduct, or illegal act or omission of RVH.
8.	I acknowledge that RVH is a teaching hospital of the University of Adelaide and consent to its students being involved in the care of the Patient in an immediate and directly supervised capacity.
9.	I consent to images (photographic and/or digital) and video being taken of the Patient and their subsequent use, only where de-identified, in teaching, research and / or publication.

➤ **Additional procedures:** *additional costs apply and are not included in the estimate of costs below*

☐ Vaccination (specify): .....

☐ Routine Blood Profiling ☐ Faecal Egg Count (FEC) ☐ Sheath Clean Other:

Cardiopulmonary Resuscitation (CPR)

In the event of respiratory or cardiac arrest, ➤ ☐ **I DO** / ☐ **DO NOT** want resuscitation and life supporting therapy performed. I understand that life-saving measures will be implemented if consented to, but may not be successful. If I DO want resuscitation and life supporting therapy performed, then I (or, if the Owner's Authorised Representative, the Owner) agree to pay all costs of that resuscitation and life supporting therapy, in additional to the original Cost Estimate. This varies from $500 - $1000 (*estimated costs only*).

➤ **Resuscitation Code (Please select box below)**

☐ Basic: Intubation and Chest compressions ☐ Do Not Resuscitate (DNR)

☐ Advanced: Intubation, chest compressions and medications

PART D – Financial Consent

Is your pet insured? ☐ Yes ☐ No

Insurance provider name: | Policy No

➤ **Estimated Costs: $_____**

I agree to the charges in relation to the Treatment and Procedures as described in this form. This is an estimate of costs only and does not cover re-visits and/or continued treatment.

As the owner/authorised agent, I agree to pay a 50% deposit upon the Patient's admission, and the account in full upon discharge of the patient.

Pet insurance: Payment is required in full at the time of service.

Nominate Payment options: ☐ Cash ☐ EFTPOS ☐ Visa ☐ Mastercard ☐ Vetpay

PART E – Authorisation

By signing below, I acknowledge the nature of these procedures, including possible complications, may occur and I accept that the success of medical or surgical treatment and aftercare cannot be guaranteed.

I understand, acknowledge and consent to the information provided in this form and the release of information to the parties indicated by me. **I consent RVH to release Patient Information including medical notes and diagnostic information to Receiving Parties, including but not limited to;**

- Insurance Companies
- Referring Veterinarians and Health Care Providers
- Any parties required by law

Any other parties approved by the Owner or Owner's Authorised Agent, evidenced by their written signed consent *or* via verbal consent provided via telephone and certified by RVH staff.

➤ **Owner / Agent Name:**		➤ **Owner / Agent Signature:**	
➤ **Date:**		➤ **Telephone:**	
➤ **Additional contact name and telephone:**			