METROPOLITAN VETERINARY HOSPITAL
ONCOLOGY DEPARTMENT
1053 S. CLEVELAND-MASSILLON ROAD, AKRON 44321 DIRECT: (330) 670-2351 FAX:330-670-2375
734 ALPHA DRIVE, HIGHLAND HEIGHTS, OH 44143 DIRECT: (216) 201-9840 FAX: (216) 539-4914

Oncology Department– New Client Information

Enclosed you will find a New Client Packet. This packet consists of our practice policies, a client information form, a history form regarding your pet's health and a consent form. Please complete these forms **prior to the appointment and email them back to us.**

Akron appointments: email them to oncologyakron@metropolitanvet.com
Cleveland appointments: email them to oncologycleveland@metropolitanvet.com

You may also bring them with you on the day of your scheduled appointment, **arriving 15 minutes early** to ensure adequate time for entry of this information into your pet's medical record.

If you have not already done so, please take a moment to contact your regular veterinarian to inform them that you have a scheduled appointment with our practice. At this time, please request they email or fax a referral form, along with all recent diagnostics and medical history from the past two years on your pet. If radiographs have been taken, please bring a copy of them with you to your appointment. We will also contact your referring veterinarian to request records. It is also important to bring all your pet's medications and supplements to their first appointment.

**Please be advised that while the best attempt will be made to perform all diagnostics the same day as the consultation, anesthetic procedures (endoscopy, CT scan, airway exams, etc.) and some lab work may require a second visit for completion. Average appointment time for the initial consultation is approximately 60-90 minutes, with additional time requirements to be determined based on the diagnostics recommended; some tests and procedures may require your pet to be here for the entire day.

In order for the doctor to successfully assess your pet, it is important that you withhold food for 12 hours prior to your appointment (water is OK), as feeding may prevent further diagnostics or procedures from being performed. If your pet is referred for a colonoscopy, please be aware that your initial appointment will be for consultation only, as a prolonged fast and additional medications are frequently necessary to perform this procedure. Additionally, **if your pet is a diabetic, please feed and administer insulin on their normal schedule.**

We require a minimum of 48-hour notice for cancellations or to reschedule any appointment. If you are unable to keep the appointment, please contact us at 330-670-2351 (Akron) or 216-201-9840 (Cleveland). Any cancellations or to reschedule any appointments without appropriate notice will be subject to a cancellation fee. Also, if you are going to be late for your appointment, please call us- arrival more than 10 minutes past your scheduled appointment time may result in rescheduling. Please call us if you have any questions or concerns.

1053 S. CLEVELAND-MASSILLON ROAD, AKRON 44321 DIRECT: (330) 670-2351 FAX:330-670-2375
734 ALPHA DRIVE, HIGHLAND HEIGHTS, OH 44143 DIRECT: (216) 201-9840 FAX: (216) 539-4914

Appointments

Appointments may be scheduled Monday through Friday from 8:00am to 5:00pm. Please schedule your recheck appointments at least 10-14 days in advance. This allows us to accommodate your schedule as best as possible. Additionally, we request scheduling your recheck appointment with the doctor that originally treated your pet. In the event two appointments are canceled without proper notice a deposit will be asked for by the receptionist when making the next appointment. This deposit will be lost if that appointment is cancelled.

Phone Calls

For continuity of care, we request that you call with progress reports and other non-urgent calls during the practice business hours Monday through Friday 8:00am to 5:00pm. Your doctor or his/her technician will return your call at their earliest opportunity. If you have a question or concern that cannot wait until your doctor returns to the office during his/her business hours, your call will be directed to the "on-call" doctor. Emergent calls placed after-hours or on the weekend will be directed to the Emergency Department.

Visiting Hours

Visiting hours are **currently only for our critical patients** during regular business hours and these must be scheduled and approved by the attending clinician. Unless otherwise arranged, the doctor may not be available to discuss the case with you while you are visiting. Please refrain from touching other animals while visiting. This is for your safety and to prevent the spread of infectious diseases. In-room visits are limited to 30 minutes once a day. If your pet is hospitalized in the ICU, your visit will be limited to 5-10 minutes once daily. This allows the ICU staff can continue providing treatment to critical patients.

Food and Medications

We encourage you to bring your pet's food and medication. This may reduce the cost of medications while hospitalized and allows for verification of dosages. We will be happy to fill or call-in prescriptions for your pet during business hours Monday through Friday. Please contact us a minimum of three business days in advance for refills of your pet's medication. A $15 fee will be assessed in the event that you require a refill after business hours or on weekends.

Personal Items

An identification collar will be placed on your pet upon admission – please take his/her leash and collar (or travel carrier, if applicable) with you. We request that you do not leave personal items (blankets, clothing, toys, etc.) with your pet. The hospital will provide appropriate bedding during your pet's stay. We cannot ensure that personal items will not be lost or damaged in the laundry.

Patient Updates

Hospital rounds for doctors and technical staff occur from 9:00am to 9:30am every morning to assess the progress of your pet. After rounds, a veterinary technician will provide you with a medical update between 10:00am and 12:00pm. He/she will let you know how your pet did overnight and discuss planned treatments and diagnostics. Your doctor will call with a medical update each evening. Calls may be made as late as 8 or 9 pm to ensure that our doctors are able to provide the best possible treatment to our patients. We realize that it is difficult to wait for information regarding your pet. Rest assured that "no news is good news" and that you will be contacted immediately in the event of an emergency or change in medical status requiring significant decisions. Communication is greatly simplified and expedited by the designation of one contact person.

Discharges

When your pet has been cleared for discharge, a veterinary technician or receptionist will contact you to schedule a release time. This is an appointment to pick up your pet. As such, this time is designated for your doctor to review your pet's discharge instructions and medications, and to answer questions that you may have. In the event that you are unable to arrive during business hours, your pet's doctor may discuss the discharge instructions with you over the phone and your pet will be released to you by the emergency staff.

Pending Results

We will call you with test results and recommendations as they become available. Please note that repeated calls to check on results create delays and prevents the staff from focusing on patient care. A veterinary technician will contact you if your pet's results are normal or indicate minor abnormalities. If questions or concerns remain after speaking with the technician, your doctor will follow up with you at his/her next available opportunity.

METROPOLITAN VETERINARY HOSPITAL

Date: ___________________________ Time: ____________________________

CLIENT INFORMATION (Please fill out all blanks applicable):

Have you ever been here before? YES NO If yes, when: ____________________ Pet Name: ___________________

Previous Doctor(s) seen here: ____

Name of person presenting pet: ____________________ Relationship to owner: ____________________________

OWNER'S NAME: ________________________________ SPOUSE/CO-OWNER: _____________________________

Address: _______________________________________ ADDRESS: ______________________________________

CITY/STATE/ZIP: _________________________________ CITY/STATE/ZIP: _________________________________

BEST phone number#:(___) __________ □cell □ home □work BEST phone number#:(___) __________ □cell □ home □work

2nd phone number#:(___) ___________ □cell □ home □work 2nd phone number#:(___) ___________ □cell □ home □work

3rd phone number#:(___) ___________ □cell □ home □work 3rd phone number#:(___) ___________ □cell □ home □work

EMPLOYER: _______________________________________ EMPLOYER:____

OCCUPATION: ____________________________________ OCCUPATION:______________________________________

E-MAIL ADDRESS: __________________________________ E-MAIL ADDRESS:__________________________________

DRIVERS LICENSE NUMBER:__________________________ DRIVERS LICENSE NUMBER:__________________________

PET INFORMATION:

PET NAME: ____

SPECIES **(circle one):** Canine or Feline Other: _____________________ Breed: __________________________________

AGE: _______ BIRTH DATE: _____________________ SEX **(circle one): Male or Male - Neutered / Female or Female – Spayed**

COLOR MARKINGS: ____ WEIGHT: ___________________________________

ANY KNOWN ALLERGIES: ____

MEDICATIONS CURRENTLY TAKING: ____

DATE OF LAST RABIES VACCINATION: ____

ATTITUDE: (CIRCLE ANY THAT APPLY)) MUZZLE / AGGRESSIVE / DOG AGGRESSIVE / PREFERS MEN / PREFERS WOMEN

REGULAR VETERINARIAN:

DOCTOR LAST NAME & PRACTICE: ____

LOCATION: ________________________________ TELEPHONE NUMBER: ____

CLINIC/DOCTOR THAT REFERRED YOU (if different than above): ____

Oncology Department - Patient History Form

Client Name: ______________________________ **Date:** ________________________

Patient Name: ____________________ **Breed:** _________________ **Age:** _________

PATIENT INFORMATION:

How long have you owned your pet?__________________; Is **your pet a rescue?** Yes No

Is your pet indoor/outdoor or both? __________________

Up to date on vaccinations? Yes No **Date of Last Vaccination:** ______________________

Does your pet have a history of fleas/ticks? Yes No **If yes, when?** ______________________

Is your pet on heartworm/ flea/ tick prevention? Yes No **What brand and date last given:** ______________

Has your pet traveled out of state? Yes No **Where/When?** ______________________

Are there any other pets in your household? Yes No **Describe:** ______________________

Diet (<u>circle all that apply</u>): Can Dry Semi-Moist Table Food Brand Name: ____________________

Animal Attitude (<u>circle all that apply</u>): Gentle Requires Muzzle Aggressive Prefers Men Prefers Women

Current Medical Problems (i.e., Why did you bring your pet for evaluation?): ______________________

How long has your pet been sick? __________________

When did your pet last eat? ______________________**AM or PM**

Have any of the following changes been observed in your pet?

Appetite: Yes No Increased Decreased Describe:

Water Intake: Yes No Increased Decreased Describe: ______________________

Weight: Yes No Increased Decreased Describe:______________________

Urinations Yes No Increased Decreased Describe: ______________________

Circle if applicable: Straining? Blood in Urine? Unusual Odor? Vaginal Discharge?

Bowel Habits: Yes No Increased Decreased Describe: ______________________

Circle if applicable: Straining? Diarrhea?Tar Colored? Fresh Blood? Mucus?

Vomiting: Yes No Increased Decreased Describe: ______________________

Coughing: Yes No Increased Decreased Describe: ______________________

Sneezing: Yes No Increased Decreased Describe: ______________________

Seizures: Yes No Increased Decreased Describe: ______________________

Skin Changes: Yes No Increased Decreased Describe: ______________________

Change in Walking: Yes No Wobbly Arthritis Describe: ______________________

Tumors/Swellings: Yes No Location: ______________ Describe: __________________

Any recent trauma/injury? ____

Current Medications (include heartworm/ flea/ tick prevention and supplements): ______________________

____

____

Pharmacy name, location & phone number that you typically use (preferred pharmacies we work with are Giant Eagle, Rite Aid, Walgreens, Discount Drug Mart and Walmart):

____

Past Medical Problems (include surgery, trauma, medical conditions, kidney failure, heart failure, etc.)

____

Has your pet ever had a blood transfusion: If yes, when? ______________________

Did your regular veterinarian give you any information for the doctor to review? Yes No

➔ If yes, circle all that apply: Referral letter and summary X-Rays Copies of test results

METROPOLITAN VETERINARY HOSPITAL
ONCOLOGY DEPARTMENT
1053 S. CLEVELAND-MASSILLON ROAD, AKRON 44321 DIRECT: (330) 670-2351 FAX:330-670-2375
734 ALPHA DRIVE, HIGHLAND HEIGHTS, OH 44143 DIRECT: (216) 201-9840 FAX: (216) 539-4914

Financial Information:

I assume all financial responsibility for **full payment of the bill** at the time that my pet is released. An estimate of cost will be provided during the initial consultation **prior to any treatment and/or diagnostics testing**. I may be asked to leave a deposit if my pet is hospitalized overnight for further treatment.

Signature: ________________________________ Date: __________________________

Consent Information:

I do hereby authorize the Oncology at Metropolitan Veterinary Hospital and its veterinarians and their assistants to treat my pet in the manner that is considered to be necessary based on their clinical and diagnostic findings. I authorize the administration of necessary treatments, anesthesia, surgery and/or the execution on necessary diagnostic tests and understand that there are certain risks with anesthetics, any medication and testing procedures.

Signature: ________________________________ Date: __________________________