SENTINEL VETERINARY MEDICAL CENTER
EMERGENCY CARE

2500 S. Garfield St, Missoula, MT 59801
Ph: 406-218-2800 Fax: 406-218-2803
info@sentinelvmc.com

AUTHORIZATION FOR CARE

Date:_____ Client #:_____ Patient #:_____ Time:_____ AM/PM ER Veterinarian:_____

Owner/Agent:_____ Phone:_____

Email: _____

Co-Owner: _____ Phone: _____

Email: _____

Address: _____
P.O Box/Street City State ZIP

Please be aware that payment is due at the time of service. An estimate will be provided for expected costs beyond initial examination prior to treatment if patient status allows. The following forms of payment are accepted:
Cash □ Credit □ Debit □ Care Credit □ Check □: SSN/Driver's License (if paying by check): _____

My signature below affirms that the information herein is correct to the best of my knowledge and that I am of legal age (at least 18 years old) to enter this agreement. It also affirms that I voluntarily seek care for my animal and authorize the doctors and staff to care for my animal in a manner they deem necessary.

Signature: _____ Date: _____

Pet's Name: _____ Age: _____ Species: Canine □ Feline □

In the unfortunate event of cardiac arrest, how would you like us to proceed?

Please perform CPR □ Do not resuscitate (DNR) □ Please note- cost of CPR alone can exceed $500.

Breed: _____ Sex: Male □ Female □

Color: _____ Spayed/neutered: YES NO

Reason for visit: _____

Primary Veterinarian/Clinic: _____

OFFICE USE ONLY: Current on Vaccines: Yes □ No □ Rabies Only □

Medications: _____Allergies to medications:_____

Previous Illness: _____

T: _____ P: _____ R: _____ MM: _____ CRT: _____ WT: _____lb _____kg

History:_____

_____

_____

_____

_____

Info Verify□____ Info Input□___ CS Log□____ Tech Cmplt□____ Rads Sent□____ Dr Cmplt□____ Form scan/attach□____

Updated 12/2/2020 BK