



# Dale City Animal Hospital

*A Noah's Ark Animal Hospital*

2980 Dale Blvd., Woodbridge, VA 22193

Phone: 703-670-6181 Website: [www.dalecityanimalhospital.com](http://www.dalecityanimalhospital.com)



**AAHA Hospital Member**

## Treatment Release Form

Client Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of Treatment: \_\_\_\_\_

Reason for Visit (Be as specific as possible. Include when symptoms were first noticed, whether the problem is worsening or improving, and any other information that might be helpful.):

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I understand that current **bordatella** (dogs only), **distemper**, and **rabies vaccines** and a current **fecal test** are all required for pets before admission to the hospital. For those pets not current, vaccines and a fecal test will be updated as long as it is deemed safe and advisable by a veterinarian.

I certify that my pet is **free of all external parasites** upon signing this release. If parasites, such as ticks or fleas, are found, I understand that my animal will be treated on admission for an additional cost.

Other services desired at additional cost: (Please check)

- Distemper Vaccine
- Rabies Vaccine
- Bordatella Vaccine
- Lyme Vaccine
- Heartworm Test
- Fecal Test

- Feline Leukemia Test
- Feline Leukemia Vaccine
- Nail Trim
- Anal Gland Expression
- Bath
- Dip or  TopSpot

Medication refill (Doctor's approval is required.) Name of medication: \_\_\_\_\_

I hereby authorize the doctors and staff at Dale City Animal Hospital to perform procedures deemed advisable for the above-described condition. In case of an emergency situation, an attempt will be made to reach me, but I understand that the veterinarians are authorized to perform any necessary procedures if they are unable to contact me. I will strive to remain available at the phone number given below. I have received an estimate in the amount of \$\_\_\_\_\_ and understand that if additional services/fees are necessary, the doctor will contact me by phone to discuss the additional services.

\_\_\_\_\_  
Signature of Authorized Agent

\_\_\_\_\_  
Phone number on day of treatment

\_\_\_\_\_  
Date signed