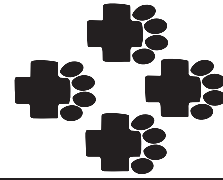
Lexington Boulevard Animal Hospital



REFERRAL CLIENT INFORMATION

Last Name: First:

Address: Zip:

Home Phone:

City: State: Work Phone:

Spouse: Fax:

Email:

Social Sec: TDL#: Occupation:

ANIMAL INFORMATION

Pet Name: Sex: Neuter/Spay:

Birthday: Age:

Breed: Color: Species:

REFERRAL DOCTOR INFORMATION

Dr. Name:

Hospital:

Address:

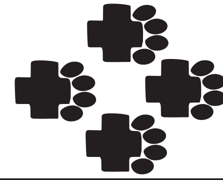
Office Phone:

Email:

Fax:

Lexington Boulevard

Animal Hospital



RESUSCITATIVE DIRECTIVE

I, , as the owner and guardian of (pet's name) understand that in an unexpected and/or emergency event the doctors at LBAH will make every effort to contact me and provide necessary medical care. If, however, they are unable to reach me, or life threatening events make it impossible to have time to reach me, I wish for him/her to:

Please check one:

Receive no resuscitative care in the event of a cardiopulmonary arrest.

Receive external cardiac compressions (but do not wish for open chest compressions) and medical attempts at resuscitation in the event of a cardiopulmonary arrest.

Receive open (cutting open the chest cavity - if necessary) chest cardiac compressions and medical resuscitative services in the event of a cardiopulmonary arrest.

Date: Signature of Owner or Agent:

I agree to these terms by supplying my digital signature.