NORTHEAST OHIO INTERNAL MEDICINE ASSOCIATES

Memo

To: **ALL CLIENTS OF THE NORTH EAST OHIO INTERNAL MEDICINE ASSOCIATES (NEOIM)**

From: **DR. LYNN TURNER**

Re: **PROTOCOL**

Metropolitan Veterinary Hospital is a 24-hour central hospital for Northeastern Ohio. Hospital services are available to you and your pet in the event of an emergency, or when NEOIM is closed. In order to better serve you and your pet, we request the following calls be made during office hours:

Tuesday – Friday; 10:30 AM – 4 PM

1.) Prescription refills: We will be happy to fill or call-in prescriptions for your pet during regular business hours. **We prefer 1-2 business days notice on medication refills**. Please be careful to maintain a small supply of medication so that your prescription can be filled before your supply is exhausted. For your convenience please follow this protocol to ensure your pet doesn't have an unnecessary lapse in medication.

2.) Progress reports: Please call with updates on your pet during regular business hours.

**If you are experiencing an emergency situation with your pet, please feel free to contact the hospital. While there are personnel on duty 24 hours a day, it is imperative that the night and weekend staff be available to handle incoming emergency cases and to monitor hospitalized cases. Your non-emergency calls are better handled during the regular practice hours.

Northeast Ohio Internal Medicine Staff

J. Lynn Turner, DVM, MS, Diplomate, American College of Veterinary Medicine

Michele Shultz, Registered Veterinary Technician

Holly Bonner, Client Liaison

NORTHEAST OHIO INTERNAL MEDICINE ASSOCIATES

Date: _____ Time: _____

Client Information (Please fill out all blanks applicable):

Have you ever been to this clinic before? YES ☐ NO ☐ If yes, when: _____ Pet Name: _____

Person presenting pet to the emergency service: _____ Relationship to owner: _____

OWNER'S NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME TEL NUMBER: _____

WORK TEL NUMBER: _____

CELL PHONE NUMBER: _____

PAGER NUMBER: _____

EMERGENCY NUMBER: _____

OCCUPATION: _____ EMPLOYER: _____

DRIVERS LICENSE NUMBER: _____ SOCIAL SECURITY NO: _____

EMAIL ADDRESS:_____

Pet Information:

PET NAME: _____

SPECIES **(check one)**: Canine ☐ Feline ☐ Other: _____ Breed: _____

AGE: _____ BIRTH DATE: _____ SEX **(check one)**: Male☐ Female☐Male-Neutered ☐ Female-Spayed☐

COLOR/MARKINGS: _____ WEIGHT: _____

ANY KNOWN ALLERGIES: _____

Regular Veterinarian:

NAME: _____

PRACTICE: _____

LOCATION: _____

TELEPHONE: _____

FAX: _____

METROPOLITAN VETERINARY HOSPITAL
NORTHEAST OHIO INTERNAL MEDICINE
DR. TURNER
PATIENT REGISTRATION FORM

Directions: **To aid the doctor in reaching an accurate diagnosis, a complete background on your pet is essential. Please fill out the following questionnaire to the best of your ability.**

What are your pet's primary symptoms? _____
How long have you owned your pet? _____
Where was your pet obtained? _____
Is your pet primarily out-of-doors or in the house? _____
Is your pet allowed to roam free? _____
Has your pet been boarded or hospitalized recently? _____
If yes, when and for what problem? _____
Are there other pets in your household? _____
If yes, what? _____
What do you feed your pet? _____
How much & how often do you feed your pet? _____
Is your pet ever fed table food? _____
Has your pet been treated for any major medical problems? _____
If yes, when and for what problem? _____
_____
Is your pet spayed or neutered? If yes, when? _____
If female and not spayed, when was the last heat cycle? _____
Is your pet currently taking any medications to prevent heartworm disease? If yes, what kind & during what months of the year?
_____
When was the date of your pet's last heartworm test? _____
Has your pet traveled out of state? If so, list states. _____

VACCINATION HISTORY:

When was your pet vaccinated against:

DOG (Canine)	***Month / Year***	***CAT (Feline)***	***Month / Year***
Distemper/hepatitis/leptospirosis	_____ / _____	Panleukopenia (feline distemper)	_____ / _____
Rabies	_____ / _____	Rabies	_____ / _____
Parvovirus	_____ / _____	Rhinotrachetitis/Calicivirus (resp. viruses)	_____ / _____
Other	_____ / _____	Other	_____ / _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE ANSWER:

Has your pet's appetite changed?	NO ☐	INCREASED ☐	DECREASED ☐	UNKNOWN ☐
Has your pet's weight changed recently?	NO ☐	INCREASED ☐	DECREASED ☐	UNKNOWN ☐
Has your pet lost any stamina lately?		YES ☐	NO ☐	UNKNOWN ☐
Is your pet drinking more water than usual?		YES ☐	NO ☐	UNKNOWN ☐
Is your pet urinating more frequently than normal?		YES ☐	NO ☐	UNKNOWN ☐
Has your pet been straining to urinate?		YES ☐	NO ☐	UNKNOWN ☐
Has your pet had blood in the urine?		YES ☐	NO ☐	UNKNOWN ☐
Has your pet vomited frequently?		YES ☐	NO ☐	UNKNOWN ☐
Have there been any recent changes to your pet's bowel movements?		YES ☐	NO ☐	UNKNOWN ☐
(i.e. frequency, amount, color, straining) Describe:		_____		
Has your pet been scratching?		YES ☐	NO ☐	UNKNOWN ☐
Has your pet had any seizures or convulsions?		YES ☐	NO ☐	UNKNOWN ☐
Has your pet had any changes in attitude or behavior?		YES ☐	NO ☐	UNKNOWN ☐
Has there been any change in your pet's walking?		YES ☐	NO ☐	UNKNOWN ☐
Have you noticed any abnormal swelling on your pet?		YES ☐	NO ☐	UNKNOWN ☐
If yes, where?		_____		
If female, has your pet had any abnormal vaginal discharge?		YES ☐	NO ☐	UNKNOWN ☐
Has your pet had unusual/unexpected reactions to medications?		YES ☐	NO ☐	UNKNOWN ☐
Has your pet had any discharge from the eyes or nose?		YES ☐	NO ☐	UNKNOWN ☐
Has your pet had any coughing or breathing difficulty?		YES ☐	NO ☐	UNKNOWN ☐

NORTHEAST OHIO INTERNAL MEDICINE ASSOCIATES

J. LYNN TURNER DVM, MS, DIPLOMATE, ACVIM

Please disable all mobile devices before entering the consultation room. Wireless access is available throughout the hospital lobby.

Thank you kindly,

Dr. Lynn Turner

Signature_____
Date_____

Your pet has been referred to the Internal Medicine practice of Dr. Lynn Turner. Please take a moment to read over the policies of the practice and sign the form at the bottom.

1. The initial consultation fee for Dr. Turner is $97.00 and a technician fee of $14.00. Other fees incurred at the time of initial presentation of your pet are the charges of Metropolitan Veterinary Hospital. These include a hospital exam room fee of $54.00 and a $23.00 fee for the initial setup costs for the medical record. Total fees for the initial visit will be $188.00

2. Recommended procedures and diagnostics will be discussed with you at the initial consultation and a written estimate will be provided.

3. Any additional procedures deemed necessary after you have been given an estimate will be discussed with you before the doctor proceeds.

4. A deposit of one-half of the written estimate will be required on hospital admission. This deposit will be applied to your total bill when you pet is released. The balance will be due when your pet leaves the hospital.

We accept Visa, MasterCard, Discover, American Express, cash and personal checks (with a valid driver's license).

I have read and understand the above policies and agree to the procedures and financial arrangements set forth in this policy.

_____ ___/___/___

(Owner's Signature)

Consult information will be forwarded to your regular veterinarian.