



YOUR NAME/S _____

STREET ADDRESS/ P O BOX: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

REGULAR VETERINARIAN: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US? FRIEND/DVM: ☐ _____
(please name)

WEB SITE: ☐ _____
(please specify)

Other: ☐ _____
(please specify)

PET'S NAME: _____ AGE _____ MALE ☐ FEMALE ☐ WEIGHT _____

DOG ☐ CAT ☐ OTHER ☐ (please specify) _____ BREED _____ NEUTERED? YES ☐ NO ☐

If applicable, please provide the name of the veterinary clinic/hospital that referred you to us:

_____ Phone _____

Have any other veterinarians seen your companion animal within the last 3 years? YES ☐ NO ☐

Name of Doctor and Clinic _____

Clinic Phone Number (if known) _____ City/State/Zip _____

Authorization for Hospice Care Treatment

I certify I am the legal owner/authorized agent for the owner of the companion animal described above and give Pets at Peace Home Hospice and Euthanasia, PLLC and any authorized agents, staff, or representatives full and complete authority to examine, prescribe for and/or treat ("hospice care") the above-described companion animal. I agree that Pets at Peace Home Hospice and Euthanasia, and any authorized agents, staff, or representatives shall not be liable for any direct, indirect, or consequential damages resulting from such hospice care.

PLEASE CONTINUE TO PAGE 2



I understand hospice care is focused on preserving quality of life for as long as possible and is NOT emergency treatment/transport. I understand that Pets at Peace Home Hospice and Euthanasia, PLLC provides services only in the HOME. Pets at Peace Home Hospice and Euthanasia, PLLC has informed me of additional diagnostics, procedures and/or more aggressive hospice care which are possible in a hospital setting, and I have: (Please check one.)

_____ Declined additional diagnostics, procedures and/or more aggressive hospice care and elect in home services.

_____ Elected to seek more aggressive care and diagnostics and will make necessary arrangements.

I assume full responsibility for the actions of the companion animal described above and all charges incurred during his/her hospice care. I also understand all professional fees are due at the time hospice care is rendered.

I have carefully read and fully understand the above provisions.

Owner/Agent Signature (circle one)

Date

P.O. Box 4746
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