AB.VMA
Alberta Veterinary Medical Association

Medical Records
HANDBOOK

ABVMA Medical Records Handbook

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Background

Council of the ABVMA has identified improving the quality of the medical records in veterinary practices as a priority.

Members of the Practice Inspection Practice Standards ("PIPS") Committee, the Practice Review Board ("PRB"), the Complaint Review Committee ("CRC") and the PIPS auditors have expressed concerns over the quality of medical records reviewed in the course of their committee work.

In 2010 there were 10 complaint cases referred to the Hearings Director for a hearing. In 9 of the 10 cases there was a finding of unprofessional conduct regarding the failure to create or maintain an appropriate medical record.

In 2011, there were 7 complaint cases referred to the Hearings Director for a hearing. In all cases, there was one or more allegation regarding the medical records.

Council, PIPS, PRB and CRC support the development of an ABVMA Medical Records Handbook, as an aide for practitioners to evaluate and improve the quality of their own records as needed.

Purpose and Objective of this Document

Professional enhancement is one of the primary responsibilities of the ABVMA. Professional enhancement is described as providing learning opportunities and tools that allow members to improve the quality of veterinary medical services delivered to the public in Alberta. This directly benefits veterinarians, animal health technologists, veterinary practices and ultimately the public.

The primary objective of this handbook is to enhance the quality of medical records and ultimately enhance veterinary medical care.

This handbook will:

- Clarify and provide guidance in the interpretation of the PIPS Bylaws regarding medical records.
- Assist PIPS, PRB, CRC, Hearing Tribunal and Council members when medical records are reviewed.
- Describe the expectations of the veterinary profession to educational institutions that provide instruction to veterinarians and animal health technologists
- Serve as the basis for an online medical records training course.

The intent is that members will gain a better understanding of acceptable standards for medical records and this will lead to a renewed appreciation for the important role that medical records play in optimizing care for veterinary patients, thereby improving the quality of medical records in Alberta veterinary practices.

Why Create and Maintain Medical Records?

Accurately Document Medical Care provided to the patient.

The primary reason for creating and maintaining a medical record is to facilitate provision of quality care to the patient. The medical record is necessary to document findings, diagnoses and treatments, so that any veterinary professional who subsequently assumes care of a patient may continue to provide quality care.

Members have a legislated responsibility to create and maintain medical records.

The Veterinary Profession Act (VPA) is legislation that regulates the practice of veterinary medicine in Alberta.

Section 56(1) of the VPA General Regulation provides that Council, on advice from PIPS, shall determine the standards of facility and service required from each category of veterinary

practice. These standards are ratified at an AGM of the Association; they are the PIPS bylaws.

The Practice Inspection and Practice Standards (PIPS) bylaws stipulate that complete, accurate medical records are maintained and available for review. Maintenance of such records is self-verified annually by all veterinary practices and is subject to audit. An audit failed on the basis of inadequate medical records may lead to either non-certification of a veterinary practice or a practice review (inquiry) of an individual veterinarian, undertaken by the Practice Review Board.

The PIPS self verification and audit activities are designed to verify practice facilities and services. PIPS will issue a practice certification upon successful completion of an audit. If PIPS identifies concerns with an individual member, PIPS may refer that member to the Practice Review Board. The Practice Review Board has authority under the VPA with the approval of Council, to conduct a review or inquiry of a member's practice. A significant portion of such an inquiry may be comprised of a medical record review.

Medical Records facilitate professional communication.

Appropriate, accurate and complete medical records are the cornerstone of effective communication between practitioners, clients, animal health technologists, staff, other veterinarians and ultimately a court of law if required.

An appropriate medical record is clear and concise, but contains sufficient detail to demonstrate the rationale for patient assessments and treatments performed as the case progresses.

Practices with multiple veterinarians, or that employ a part-time or locum veterinarian, will often have patients that are provided care by more than one veterinarian. Complete medical records (including history, physical exam findings, tentative and differential diagnoses, treatments, client communication and follow up instructions) will allow subsequent veterinary medical professionals and care givers to provide continuity and a consistent level of care for the patient, as well as improve client compliance and satisfaction.

Referral and emergency centers benefit from complete medical records that accompany referrals and in many cases such information may prevent repetitive tests.

Complete medical records ultimately provide the framework for ongoing professional relationships and open lines of communication with clients and colleagues.

Medical records are the basis for peer review of the adequacy of patient care.

An appropriate and complete medical record is the basis of a veterinarian's defense of their professional conduct. The adage 'if it isn't written down, then it didn't happen' holds true in professional conduct proceedings.

It is important to clearly document the history and presenting complaint, physical examination findings, diagnostic testing results, differential diagnoses, treatments (including dose, route, frequency and duration), prognosis, all client communications and follow up instructions. Any tests, treatments, or referral options that are declined by the client at the time of presentation should be documented in the medical record.

Inadequate communication is a common underlying factor in complaint cases. A summary of all client communication methods including in-person, electronic and telephone conversations (with veterinarians, animal health technologists and non-medical staff) must be recorded in the medical record. Failure to do so may lead to miscommunication, misunderstandings, errors and client dissatisfaction - all of which may lead to a complaint against a veterinarian.

A properly maintained medical record may be the best defense against a complaint of unprofessional conduct or a civil lawsuit. On the other hand an incomplete or illegible medical record could be interpreted as an indication of professional incompetence and lead one to believe that medical care may have fallen below an acceptable standard.

In the event a complaint of unprofessional conduct or unskilled practice is received regarding a member, an investigation into the matter is usually conducted. In all cases the member complained against is required to respond to the letter of complaint and submit relevant documents including medical records that pertain to the complaint.

The Complaint Review Committee, Hearing Tribunal and Council may review the investigator's report which customarily includes medical records.

Upon reviewing the investigator's report, the CRC makes a preliminary, threshold decision to either dismiss the complaint or refer the matter for a hearing. In the event there is an incomplete or no medical record to support the member's actions, the case is likely to be referred for a hearing. There have been cases where despite provision of adequate medical care, a member was required to appear before a hearing tribunal due to incomplete medical records of that care.

Committee members are peers and understand the nuances of veterinary medicine. Veterinarians and animal health technologists recognize adequate care and can readily identify details that don't make sense. Strive to prepare every record as if it will be reviewed by your peers.

Complete medical records can help avoid medical errors.

The act of creating a complete medical record causes the practitioner to thoughtfully articulate the reasoning for the treatment or diagnostic plan. The exercise of systematically compiling the medical record will assist in preventing errors or omissions in a complex case.

It is important that all treatments (including dose, route, frequency and duration) are recorded in the medical record. Proper documentation is essential in helping to prevent potentially harmful drug interactions.

It is also crucial that adverse side effects are documented in the medical record. If it is recorded that a patient reacted negatively to a medication in the past, repeated use can be avoided.

Good medical records lead to good patient care.

The ultimate justification for keeping appropriate medical records is the provision of quality care for the patient. There is ample evidence that good medical records lead to good patient care. Quality medical records and patient care with documentation of informed consent may increase owner compliance and as a result may increase the level of care provided.

Good medical records lead to good business.

A persuasive reason to create and maintain excellent medical records is that consistently good medical records correlate with enhanced medical care and this is good for business.

An increase in the quality of patient care provided and the resultant increase in owner compliance with diagnostic tests, treatments and follow up examinations and consultations will increase net revenues for a practice.

A direct benefit of accurate and timely completion of medical record is the avoidance of omissions and errors with billing.

Consistently poor medical records correlate with and actually can result in poor medical care.

The reverse of the above holds true in that incomplete records that lack detail can result in incomplete examinations, erroneous differential diagnoses, missed or incorrect treatments, recurrence of adverse reactions or lack of response to treatments and overall poor patient care.

The Complaint Review Committee, when reviewing an investigator's report will assess the information provided by a medical record. The CRC may determine that the medical record is deficient, but the overall medical care of the case is acceptable. Generally, in that case the CRC will not refer the matter for a hearing based solely on the medical record deficiencies. However, if the medical record is reflective of a poor quality of medicine practiced, then the CRC will proceed accordingly.

The PIPS Committee will review the medical records of a practice as part of a PIPS audit. The auditor will often find medical records that do not meet the PIPS standard. This is either a practice issue where all medical records and their management should be addressed or it is an individual member issue that is reflected in a practice audit.

The PIPS committee may address a deficiency in medical records at the practice level by requesting that corrective actions be taken and follow up audits are performed. The PIPS committee may identify medical records that suggest a deficiency in an individual member's ability to practice veterinary medicine. This member is referred to the PRB, which conducts a review of that member's practice.

Collect and Archive Data

An appropriate medical record and management system will provide a concise and logical means of retrieving information in a timely fashion that optimizes patient care. An archive of good medical records will help identify problems and patterns, advance medical knowledge and provide for health and disease surveillance.

Benefits the Integrity of the Profession

Maintaining complete and appropriate medical record upholds the integrity of the veterinary profession and distinguishes veterinarians and animal health technologists from those in the public who are encroaching into certain facets of veterinary medicine. This lends credence to our quest to maintain our professional independence and self-regulatory status.

What is Expected from Members?

Following are general statements regarding medical records that succinctly describe what is expected from veterinary health care professional with respect to creation and maintenance of medical records.

These expectations are the standard that is established by members of the profession and applied by peer review groups that examine medical records. This is not a standard of perfection. It is established by reasonable veterinarians engaged in the similar practice of veterinary medicine.

This standard is consistent with the PIPS Bylaws on medical records and upholds the mandate to protect both the public and the integrity of the veterinary profession.

- A practice must maintain records in such a way that any veterinary health care professional may proceed with continuity of care and treatment of any given case.
- Medical records must be legible on hard copy or maintained electronically with appropriate safeguards to ensure permanency and inability to alter after an entry is made.
- The medical record must demonstrate an appropriate level of medical care is provided to the patient/herd.
- Medical records must ensure sufficient information has been entered into the history and exam portions to justify a tentative diagnosis, problem list and treatment plan.

- Medical records must clearly indicate the author of the medical record, and this must be permanently and uniquely identified in a manner that is understood by anyone examining such records. Each entry in the medical record must be dated and signed, or initialed.
- Medical records must be complete, concise, timely and contemporaneous.
- The medical record is permanent; that is, nothing in the medical record should be erased, covered with correction fluid or in any way obliterated. A single line may be drawn through errors, then date and sign. Addendums and corrections must be clear.
- Medical records may include standard abbreviations that are unambiguous, and medical terminology for improved accuracy and efficiency. A list of all non-standard abbreviations used should be approved and maintained by the hospital.

Food Animal Medical Records

- Food animal medical records must meet the Practice Inspection Practice Standards bylaws. It is acknowledged that the structure and content of the food animal medical record will differ from conventional individual animal medical records.
- Food animal medical records may identify groups of animals and/or individual animals. Food animal medical records may document individual animal examinations, procedures and treatments and/or producer consultations, herd health programs, laboratory reports, and animal health protocols.
- Food animal medical records must achieve the same objectives of appropriate creation and maintenance of medical records, which is to document findings, diagnoses and treatments, so that any veterinary professional who subsequently assumes care of a patient may continue to provide quality care.
- The importance an appropriate medical record may be increased when the veterinarian deals with large production facilities or large numbers of animals, as there will be increased liability. Food animal medical records may be subject to increased scrutiny given societal concern of food safety.

What is the Medical Record?

Any document or information relevant to veterinary medical service delivery may be considered part of the medical record.

The medical record is often thought of as the paper chart or file and its contents, which is the paper based folder or computer equivalent containing:

- Client information
- Patient information
- Patient history
- Problem List
- Exam Findings
- Results of client consultations and recommendations
- Progress/Medical notes
- Surgery/Procedures reports
- Anesthesia monitoring record
- Laboratory reports
- Reports from consultants

In fact, the medical record is comprised of all documents and items with information regarding the care of a patient, which not only includes the medical chart, but also includes:

- Health certificates
- Appointment schedules
- Invoices and statements
- Letters, phone logs, records of client communications
- Consent forms
- Discharge Instructions
- Photographs
- Digital and electronic data
- Radiographs and interpretations
- Surgery, Anesthesia and Radiology logs
- Controlled Drug Logs
- Diagnostic Imaging (e.g. Ultrasound/CT images) and interpretations

Medical Record Formats

Records need to be organized, logical and self-explanatory. To accomplish this, a format may be used to provide structure and consistency. This format also allows a ready transfer of files between facilities and practitioners, and helps ensure all relevant information is properly recorded. The use of a standardized medical record format is important in computerized medical records as well.

There are several different formats of medical records that may be employed by veterinary medical practitioners. The format of the medical record used in a practice is the discretion of the veterinary medical practitioner. The Problem Oriented Medical Record (POMR) may be regarded as the gold standard for creating and maintaining medical records.

Problem Oriented Medical Record (POMR)

A POMR enhances the medical process by improving documentation of the medical logic. It organizes information in the record by problem. Additional diagnostics and treatments are based on refinement of the problems and the diagnosis. This format requires discipline of thought , extra effort and is well suited to complex cases. A pattern or underlying cause may become evident when reviewing the problem list. The problem list is limited to current knowledge and understanding of the case.

POMR includes:

1. Date
2. Presenting complaint by client or alternate caregiver
3. Pertinent history
4. Patient evaluation, exam findings
5. Problem(s) listed
6. Assessment of the complaints, the history and the problems in order to come up with a tentative diagnosis or rule outs
7. Refine the problem list, develop a plan of action, implement the plan and re-evaluate
8. Diagnostic and therapeutic plans
9. Medications prescribed or administered with amount, dosage, frequency and duration as indicated on prescription label.
10. Prognosis in complex or serious cases

SOAP Charting

True SOAP charting calls for conducting a Subjective-Objective-Assessment-Plan (SOAP) on each *problem* identified. This is an excellent teaching tool, however it may be impractical in a veterinary practice setting. A SOAP charting format where the *patient* rather than each *problem* is SOAPed, is acceptable.

S.O.A.P

a) Subjective
Data from secondary sources, such as history from the owner
This data may not be qualified or verifiable

b) Objective
Data from direct examination and from verifiable sources

c) Assessment
Documentation of the understanding of the data
Differential diagnosis list

d) Plan
Treatment, additional diagnostics other decisions

Other Medical Record Formats and Charting Methods

Charting by Exception

This is a medical record format where only the abnormal findings are recorded. Veterinarians may be using charting by exception and not realize it. This format does not hold up well to scrutiny, and does not provide information that something did or did not happen.

If no record is made, the assumption is that the condition was monitored and all was normal. Inconsistencies in the medical record will undermine the value of the record.

Charting by exception is not an acceptable standard for medical records.

Source Oriented Medical Record

This is a chronological narrative that is organized only by the source of the information. Source oriented medical records are a fast way to complete handwritten records, but lack a logical structure. Review of source oriented medical records is challenging as information is not systematically documented and is often limited.

The creation of this record does not force a systematic or logic based review of the case, as in a SOAP format. This medical record format generally does not meet the minimum standard and does not stand up to peer review.

Medical Record Content

The following objectives for medical records content and maintenance should be regarded as a minimum standard with a goal of advancement at every opportunity.

The ABVMA requires a medical record system that includes the following:

Client Identification

Client, and patient or herd information that is complete, contemporaneous, clear, legible, clinically oriented, and is retrievable on an individual, corporate or herd (flock) basis.

It is advisable to collect as much client contact information as possible. Use of a separate client information sheet and/or a new client registration form is recommended.

Client Information minimum data:

- Name Mailing address, home address if different
- Phone numbers – residence, business and cell phone
- Email address
- Alternate caregivers
  - If the client will be absent while the patient is being cared for, the name address and phone number of the person to contact in the event decisions regarding patient care are required

Patient / Herd / Group Identification

The patient in most cases is easily identified as an individual animal. In Food Animal Practice, the patient may be a herd, a sub-group defined by age or sex, a pen, or entire production facility. The patient is defined to the level that is appropriate.

Patient Information minimum data (where appropriate):

- Name
- I.D. Number (if applicable)
- Species
- Breed (where appropriate)
- Age or Date of Birth
  - Age is best indicated by birth date so that age can be calculated at any time.
- Sex/altered
  - Gender should be clearly stated and not inferred from other information. A patient is considered intact unless otherwise noted.
- Weight
  - Current weight and unit of measure (kg or lb) is clearly indicated, or is estimated in the case of large animals.
- Color/markings, including scars, horns, antlers etc.
- Microchip/tattoo if available
- Immunization records
- CCIA (Canadian Cattle Identification Association) Tag #
- Pen or Lot #
- Other Tag# (Rabies)
- Brands, (freeze or hot iron)
- Premise ID Number
- A clear description of where the animals are normally housed, in addition to where they were treated – street address (legal/land description), directions, GPS, etc.
- Maintain a current list that summarizes the patient or herd problems.
- Maintain a current list of long-term medications/ therapy.

Initial Differential Diagnosis

The medical record contains, at minimum, sufficient information entered into the history and exam findings of the medical record to justify a tentative or differential diagnoses, diagnostic plan and treatment plan.

- History of previous and present illness, medical treatments, and responses, vaccination status and parasite control measures.
- A Master Problem List is used to allow rapid access to a patient's history including vaccination, chronic conditions, long term medications and resolved or recurrent problems, routine medical tests, allergy warnings.
- Physical examination findings are recorded in detail.
  - Templates may be used – see discussion below.
  - Recording "PE-NAF" is not appropriate unless accompanied by a protocol detailing what is included in the abbreviation.
  - Observations of groups of animals may be appropriate.
- Each problem is defined at the current level of understanding of the case. The medical record is continually updated as further information is acquired, the understanding is refined and new assessments are made.
- Prognosis is recorded and continually updated as understanding of the case is refined, and the medical record contains a final or up-to-date assessment of the patient.

Progress of Care / Medical Notes

Information is documented and continually updated as the case progresses including:

- Current information is entered contemporaneously (at the time of treatment or service) every time the animal is "seen."

The assessment of the patient is critical; documentation of procedures performed without an assessment of the patient is not a complete medical record.

- 'Seen' in this context refers to any procedure, client communication, assessment, observation, progress note and dispensation of products or pharmaceuticals. All entries must be dated and signed or initialed.
- Updates or changes in therapy / treatment plan, including those recommended over the phone, are all documented.
- Documentation of all phone conversations and electronic communications with the client are essential components of the medical record.
- Documentation of all drugs administered including dose, route, frequency and time of administration.
- Procedures performed with accurate descriptions are recorded in chronological order.
- Documentation of the response to the care or treatment provided.
- A comprehensive view of the patient with good communication of medical logic.

Prescribing/Dispensing Activities

The "Council Guidelines Regarding Prescribing, Dispensing Compounding and Selling Pharmaceuticals," documents the requirement for record keeping when prescribing and dispensing activities are undertaken.

- In every instance where a prescription is issued, the medical record should support the existence of a VCPR[1].
- The medical record must document that medical need is established for the prescribed treatment by the prescribing veterinarian.
- The medical record will document required elements of a prescription including *(taken from ABVMA Council Guidelines)*
  - Prescribing practitioner and contact information
  - Patient owner/agent
  - Date of prescription
  - Patient
  - Name of drug prescribed and concentration
  - Quantity of drug
  - Direction for use, including dose, route of administration, frequency and duration
  - Substitution (yes/no) of same drug (different brand name)
  - Number of refills (repeats, zero if not indicated)
  - Withdrawal time
  - Signature of veterinarian
  - Warnings or side effects
- The prescription does not necessarily need to appear in the medical record, as it would appear on a stand alone prescription issued to a client to be filled elsewhere. However, all of the elements of the prescription must be contained in the medical record.
- A prescription may refer to a treatment protocol that exists as part of a herd health program.
- A second copy of the prescription label may be included in the medical record as an efficient way to document this information.
- Medical records will document appropriate dispensing activities including:
  - Maintaining an appropriate medical record for each client/patient.
  - Maintaining the original prescription that is being filled.
  - Maintaining a declining balance of refills.
- The medical record should document the identity of the compounding pharmacy for any compounded drugs dispensed.

[1] Veterinary-Client-Patient-Relationship – see section 21.1 of the VPA General Regulation.

Anesthesia

- A record of the anesthetic protocol, including names of drugs, time of administration, dosages and route of administration of induction agent, as well as the concentration of the maintenance agent and any changes made to doses or concentration.

A record of the anesthetic monitoring is required.

- A time based record of the patient's heart rate and respiratory rate is required. Current PIPS bylaws require a minimum anesthetic monitoring of cardiac and respiratory rates, which may be accomplished by a registered animal health technologist or by electronic monitoring.
- In addition, a record of additional monitoring employed, including capillary refill time, pulse oximetry, blood pressure, end tidal capnography, Doppler, depth of anesthetic, anesthetic risk score, pain score, etc. is recommended. It is suggested that the medical record include all relevant information regarding the anesthetic protocol and the physiologic parameters in the event of an adverse reaction or death.
- If a patient is intubated, the size of the tube, and the presence or absence of a cuff and inflation of the cuff, should be recorded.
- A sample anesthetic monitoring form is included in the appendix.

Surgery

The medical record contains a written record of all surgical procedures including details of approach, findings, type of repair, suture material used, any material implanted, the closure technique used, duration of surgery and identity of surgeon.

- Reference may be made to a specific text, author and page, or standard operating procedures (SOP) manual, for elective and repetitive procedures. (e.g. cruciate surgery; ovariohysterectomy/neuter).
- **Any procedure described in a record as being "routine" shall have a corresponding Standard Operating Procedure (SOP).** For example, "Routine Castration" may be written in a record provided that a complete description of the procedure for each veterinarian on a given species is on file and available for reference.

Documentation of Client Communication

The best way to avoid a complaint is through proper communication. The medical record needs to include an account of all communication with the client. Maintaining a record of communication will help to protect the veterinarian and/or animal health technologist in the event of a complaint. The medical record is not a transcription of the conversation but contains enough information to know what was discussed and eventually consented to or declined by the client.

- The medical record will document all client communications by all staff members including unsuccessful attempts to reach client.
- Descriptions of all advice given must be clearly documented, including diagnostic, surgical and treatment options and their implications. Computer software can greatly simplify standard descriptions of procedures, risks, costs, etc.
- In person and telephone communication with clients or alternate caregivers should be documented in the record by date. Voicemail box phone messages should be documented, including the number called, time and date.
- Include all communication with alternate caregivers.
- The medical record documents discharge instructions, or references the standardized discharge instructions, given to client especially in complex cases.

Documentation of Informed Consent

The duty of the healthcare provider is to inform the client of all material facts needed to determine whether or not to consent to treatment. The act of consent when a client has all the facts, is informed consent.

  - Material facts are set forth in a language that a legally competent person can reasonably be expected to understand.
  - The definition of material facts is the facts to which a reasonably prudent person will attach significance, in deciding to agree to a treatment or procedure.
- The requirement is to document, by way of signature, that the informed consent was received for a specific prescribed

treatment, procedure or diagnostic test on a case by case basis. This includes:

- Nature and character of the treatment or procedure proposed
- Anticipated results
- Recognized possible alternative forms of treatment and non-treatment
- Possible material risks or complications
- Potential treatment benefits
- Estimated cost of care
- A generic statement on the consent form informing the owner that students may be involved in treatment of their animals, if applicable

- If consent is not documented in writing with a signature, The medical record should reflect that verbal consent has been received and contain an explanation why written consent with signature was not obtained.
- Recommendations and estimates, including those for surgical or medical treatment, diagnostic testing or referral should be documented in a treatment plan.
- Specific treatments, procedures and/or diagnostic tests that are declined by the owner/client, including the reasons given by the client must be documented in the medical record. Details of the ensuing discussion regarding risks of not pursuing treatment are also documented.
- Documentation of specific treatments, procedures or diagnostic tests that are cancelled by the client, including the reasons given for cancellation.
- Consider obtaining a written release when client is not following recommendations.
- Euthanasia consent must be documented, including declaration by owner or agent that the animal has not bitten anyone in the previous 10 days.
- Documentation of authority to provide consent that has been granted by the client to an alternate caregiver.
- Documentation of consent received to delegate veterinary medical tasks to a student that is engaged in the practice of veterinary medicine pursuant to Registrar approval. It is recommended that a generic statement is included on the consent forms informing the animal owner that students may be involved in the treatment of their animals.

Radiographs

- Radiographs, ultrasound files and all digital imaging are considered part of the medical record, and are maintained accordingly.
- The medical record should document the results of any diagnostic imaging investigations or studies, with the specific images available to accompany the medical record if necessary.
- Radiographs should meet the codes of practice in the ABVMA Radiation Protection Program, specifically with respect to identification and labeling of radiographs and maintenance of the radiology log.
  - Identification
  - Log
  - Maintenance

Consultation Reports

The medical record includes:

- Documentation of all consultation(s) with specialists or referral to other veterinarians including names, dates, procedures and recommendations. This information may be provided by referral letter or documented phone conversation.
- Laboratory reports and interpretations, and reports and assessments of diagnostic procedures performed. Includes pathology, radiology, histopathology, cardiograms, etc. as applicable.

The veterinary practice entity (VPE) should consider implementing a system that tracks both in-house and send out laboratory samples. This system may document where and when each sample is sent and when the results are received, including the interpretation discussed with the client.

Hospitalized Patients / Critical Care Flowsheets

- The medical record will include a 'Hospitalized Patient' medical record which is separate and distinct from 'Out Patient' records that clearly shows:
  - Name(s) and dosage of all medications(s) given,
  - Time(s) of all medication administered,
  - Date and frequency of medication administered,
  - Dosage and rate of fluids, total volume of fluids administered,
  - Duration of all treatments,
  - I.D. of those who administer treatment.

IV Fluids

- Include the type of fluids administered, rate of administration, changes to rate of administration, when the change occurred, all drugs added to the fluids and the total amount of fluids administered.

Medical Record Management

Medical Record Management refers to the clerical creation and maintenance of the medical records as opposed to the information that is contained in them.

Entries

- An appropriate medical record shall be legibly written, typed or computer generated. Members must ensure that records can be read and interpreted to avoid misunderstandings which are detrimental to the patient.
- Changes to typewritten or medical records should be designated with a single line through the text or other suitable technique that preserves the original entry. All changes should be dated and initialed.
- An entry is defined as any notation regarding a procedure, client consultation or communication, assessment, observation, progress note, and dispensing products or pharmaceuticals.
- There is a date and signature, or initial for each entry. Time stamp of computer entries is preferred.
- Entries made by non-veterinary medical staff must be initialed by the staff member but do not need to be initialed by a veterinarian or AHT.

Alterations to the Medical Record

Under no circumstance is any information to be permanently deleted from a medical record. This includes owner information such as owner's name, phone numbers, addresses and all information entered in the medical record.

All entries are to be made as of the date and time that the entry is actually made in the medical record. If information becomes available or information is recalled after a period of time, this information is entered, signed and dated as of when the entry is actually made.

New information may contradict information that exists in the medical record, but the old information must remain in the record.

Templates

- Templates can make record keeping more efficient. A template is a diagram, chart or checklist utilized to document information for quick recording and documentation.
- Lesions may be drawn on a diagram to indicate size and location, e.g. eye, dental and dermatological examinations.
- There is benefit to taking some time to compose an appropriate medical record in terms of giving due thought and consideration to the medical management of the case. In this respect, there is a limitation to the extent that templates should be used.

Members are cautioned regarding the use of a template consisting of check boxes, as this may place the member at greater risk in a civil court or professional misconduct hearing if no notes on the actual finding accompany the template.

- Members should not use default normal descriptions of body systems when using a computerized medical records program.

The medical record should not have a detailed description of a body system if the system was not examined, or if the description does not accurately reflect what is found.

- The medical record entry should have an accurate description of the actual findings of the system or body part examined.

Standard Operating Procedures (SOP) / Protocols

A medical record can make reference to a standard operating procedure (SOP). An SOP is a detailed description of a 'routine' procedure including a surgery and outlines in detail a particular way that the procedure, assessment or surgery is performed by a specific practitioner in the majority of cases.

- All current and archived SOPs are maintained in the VPE and accessible to and referenced by all staff.
- All SOPs are dated with a commencement and, if applicable, a termination date.
- SOPs contain references to texts, journals or current websites such as VIN.
- All material sourced from websites should be printed and maintained with the SOP.

- Any variances from the SOP are recorded in the medical record with enough detail to explain the variance

Abbreviations

- Standard abbreviations and accepted medical terminology are used in medical records.
- A complete list of VPE approved abbreviations is maintained and available for reference.

Storage of Medical Records

- All components of the medical records are kept in a systematic matter. A systematic approach to medical record storage can help ensure timely retrieval and that no relevant information is overlooked or misplaced.
- The VPE will have a consistent and dependable method of client and patient or herd identification that permits dependable identification and retrieval of medical records, for example by colored file tabs or identification numbers for each patient.
- All components of the medical record are linked by a unique identifier relating to the patient. When files or reports are maintained in different locations (within the VPE or between locations), there exists a cross indexing system which allows for prompt retrieval and intra or inter-facility use.
- Medical records are kept current, and must be completed in a timely manner.
- A quality assurance system exists that ensures records are not filed before medical records are completed and signed.

Maintenance and Retention of Medical Records

Every VPE has an obligation to retain medical records.

- Dead animal files are maintained for 5 years.
- Records (including radiographs) are maintained for 5 years after the last patient visit.
- Original fax prescription forms are maintained for 5 years

Client Access to Information

- The client owns the information in the medical record and must be granted access to that information upon request. This is best accomplished by providing a copy of the medical record.
- Medical records are available to the public during regular business hours.
- Clients may request that the medical record be transferred to another veterinary practice entity. The medical record must be transferred in it's entirety to the requesting veterinarian or veterinary practice upon receipt of the request and client consent.
- A VPE may charge a reasonable fee for copying or faxing a medical record.

Large Animal / Food Animal Specific

- Records are created and maintained of all visits to production sites.
- A herd consultation report is provided to the client following visitation to the production site.

Referral Emergency Records

A VPE that provides referral emergency treatment must provide discharge forms in triplicate - one copy each for:

- the medical record
- client
- primary Care Veterinarian (mailed if necessary)

Disposition of Medical Records Upon Ceasing Practice

Any member who ceases to practice, for any reason, or upon death, their Executor shall:

a) Retain all medical records for 5 years; or

b) Transfer all medical records to a member who assumes responsibility for the practice, including the medical records; or

c) Transfer all medical records to:

i. Another member practicing in that locality, or

ii. A secure storage area with a person designated to allow all veterinarians reasonable access to the records; and

d) Publish a notice in the local or area newspaper indicating where the records can be accessed.

Log Books

The following logs are maintained in hard copy or are immediately retrievable from a computer system, and contain the identified information. These log books are totaled or reconciled by month and year. There must be a date and signature or initial for each entry. A time stamp is preferred.

Surgery Log

Members should consider including the following information in the Surgery Log.

- The date of the procedure
- The name of the client
- The breed, age, sex, weight and identity of the animal upon which the procedure is performed
- The name of the surgeon

- The nature of the procedure
- The animal's pre-operative condition e.g. whether the animal was healthy, indicated mild disease, indicated an existing disease with mild systemic reaction, or indicated acute or severe systemic disease
- The animal's post-operative condition, e.g. whether the animal demonstrated an unremarkable condition and status during the post surgical period, required post-surgical care, or died during or shortly after surgery
- The length of time taken to perform the procedure

Anesthetic Log

Members should consider including the following information in the Anesthetic Log.

- The date of the induction
- The name of the client
- The breed, age, sex, weight and identity of the anesthetized animal
- The pre-anesthetic condition of the animal, e.g. whether the animal was healthy, indicated mild disease, indicated an existing disease with mild systemic reaction, or indicated acute or severe systemic disease
- The name, dose, route of administration of any pre-anesthetic agents
- The name, dose and route of administration of anesthetic agents
- The nature of the procedures performed under the anesthetic
- The post anesthetic condition of the animal, e.g. whether the animal recovered normally, demonstrated vocalization, excitement or paddling, demonstrated extreme vocalization, convulsion or vomiting, suffered cardiac or respiratory arrest, or died.

Surgery and Anesthetic logs may coincide, that is, be combined into one log. Chronological storage of individual surgery and anesthesia monitoring record sheets may satisfy the requirement for a surgery/anesthesia log.

Narcotic, Controlled and Targeted drugs logs:

- Acquisition Log:
  - product, strength and quantity
  - invoice #
  - date received
  - lot #
- Use Log – an entry is made for any and all usage of a controlled substance including dispensing, use in clinic or compounded in clinic.
  - Product, strength and quantity
  - bottle #
  - how and when drug is used
  - declining balance or method to determine quantity remaining
- Separate narcotic, controlled and targeted drug logs (acquisition and use) are maintained for each narcotic, controlled or targeted substance, including products compounded in a VPE, e.g. premedication mixes of BAG.
- Narcotic, controlled and targeted drug logs (acquisition and use) are reconciled weekly and monthly.
- The 'pharmacy' copy of the TPP for narcotics that are prescribed and dispensed is maintained in the narcotic, controlled and targeted drug log.
- Narcotics log is signed or initialed by the prescribing or dispensing veterinarian.
- The surgery or anesthesia log cannot be used as a narcotics and controlled drugs log.

Radiology Log

Members must include the following information in the Radiology Log.

- owner and patient identification
- exposure technique (kVp, mA, time)
- body part thickness
- includes dental images

Information may be tracked electronically for digital systems.

Computerized Log Books

Many Alberta veterinary practices create and maintain computerized medical records. The PIPS committee has been reviewing the requirements for hard copies of individual logs.

- Narcotics Log: The Narcotics Control Branch (Federal Government) requests that a hard copy be maintained for a minimum of two years, after which time a computerized (disc or hard drive) log may be kept. Computerized logs must be easily retrievable and appropriately backed up to ensure against information loss.
- Anesthetic and Surgical Logs: may be kept entirely on computer if they are easily retrievable and appropriately backed up to ensure against information loss. Anesthetic and surgical logs must be maintained separate from patient records, unless they can be easily retrieved as a log separate from other patient data.
- Radiology Log including Quality Control Logs: may be kept entirely on computer if they are easily retrievable and appropriately backed up to ensure against information loss.

Computerized Medical Records

- Computerized medical records shall be in compliance with Practice Inspection Practice Standards Bylaws
- **Computerized medical records must meet the same criteria as non-computerized records as stated in the ABVMA bylaws.**
- The records may be created and maintained in an electronic computer system providing:
  - the system provides a visual display of recorded information;
  - the system is capable of printing the information promptly;
  - the system retrieves information by owner and/or patient name;
  - the system is password protected or otherwise provides reasonable protection against unauthorized access. Passwords are made available to authorized personnel to provide for continuity of access;
  - the system backs up files and allows recovery of backed up files or otherwise protects against loss of, damage to, and unauthorized access to information;
  - the system is capable of displaying the recorded information of each patient in chronological order;
  - the system records the date and time for each entry of information for each patient;
  - the system indicates any changes in recorded information as changed, and preserves the original content of the recorded information when changed or updated.

Limitations of Paper Records

Conventional paper records or charts are ubiquitous in veterinary profession. Paper records comply with current ABVMA bylaws, though there are some limitations to the paper medical records.

The conventional file system is a single use, at a single location view of the data in the medical record.

- The paper record entries are generally verbose open ended narratives. Finding and comparing data is difficult.
- Drawing a conclusion that the data does not exist requires examination of the entire record.
- Finding inconsistencies requires keeping the entire record in memory.

Privacy of Information

Provincial and Federal Legislation apply regarding the collection of personal information. The Privacy Act covers the personal information handling practices of the federal government. The Personal Information Protection Act or PIPA covers the provincial privacy laws for the private sector in Alberta.

Personal information is described as including any factual or subjective information, recorded or not, about an identifiable individual. This information can include information such as name, gender, ethnic origin, blood type, family status, health history, conditions, views, opinions, comments, disciplinary actions, employee information, etc.

Personal information contained in medical records and veterinary practices must comply with PIPA.

Each VPE should implement a privacy policy and procedure system. This provides you with the opportunity to review and revise your organization's practices should there be the need. Documentation and exceptional medical record management are key and few adjustments should need to be made. Implement a privacy policy that works for your particular practice or situation. There are some simple steps to help get you started. They are summarized as:

1) Appoint an Information Officer to oversee and implement the system.
2) Review your policies and practices for collecting, using, and disclosing personal information.
3) Implement safeguards to protect personal information. Confidentiality is a must.
4) Ensure individuals have the right to access and correct any personal information that is incorrect.
5) Implement a retention and destruction policy.
6) Get consent from your clients for the collection, use and disclosure of private information.

The information collected regarding a client and the patient belongs to the client. They have the right to access that information and view or take a copy of the medical record.

The practice is required to maintain the medical record in a secure fashion and safeguard from unauthorized viewing or access.

Further Information available at:
members.abvma.ca/Operating/Privacy-and-information-management.asp

Medical Records Officer

It can be beneficial for a medical record management system to be properly documented and maintained by a designated individual.

- Veterinary practices should designate a "Medical Records Officer" within the practice who is responsible for implementing the policy.
- Consider written protocols for the practice that details the medical record management.

Medical Records Discipline Cases - Review

2010

In 2010 there were 30 formal complaints received at the ABVMA. 10 of those cases were referred by the Complaints Review Committee to the Hearings Director for a hearing. Of those 10 cases, 9 had a finding or an allegation of failure to create or maintain a medical record that meets the acceptable professional standard. This statistic is concerning. Here is a review the 2010 cases that were referred to a hearing that had an allegation regarding medical records.

Case # 10-01, published May-June 2011

"That the veterinarian failed to complete appropriate medical records with respect to the dog, particularly with respect to the Second Surgery."

This case involved dental extractions and centered on which incisors were removed and why. A complete medical record would have contained the appropriate forms indicating that informed consent was obtained for removal of specific teeth. If the veterinarian had determined during surgery that additional or different teeth needed to be removed and had documented the actions taken and why, the CRC may have looked at the case differently. As it stood, there was no record of which teeth were removed, and the fact that permanent teeth were removed was unknown to the complainant until the investigator conducted the interview.

Case #10-07, published Mar-April 2011

"That the veterinarian failed to create a proper medical record with respect to the veterinary medical services provided to the dog."

This was a case where the veterinarian maintained he was acting as the Good Samaritan and treated the dog without making any record. Had the veterinarian made a record of what was done and the prescriptions and forms indicating informed consent were obtained, this case likely would have been dismissed. If it is not written down, it didn't happen. If a record does not exist, there is no question - that case will be referred for a hearing.

Case #10-09, published May-June 2011

"That the veterinarian failed to maintain proper medical records with respect to the veterinary medical services provided to the dog, including but not limited to the absence of an anesthetic record."

This case had some discussion with respect to the fact that there is not a specific requirement in the bylaws to make a record of anesthetic monitoring. It was noted by the discipline committees that it is assumed that one would need to create a record of anesthetic monitoring as it is a medical procedure and the monitoring would be useless without making a record of it. The QA Self Verification Guide has a clear requirement that an anesthetic record is created for each patient. Had the veterinarian in this case recorded the vitals and the time at which they were checked, the CRC may have formed an opinion that the veterinarian had appropriately monitored and not referred the case for a hearing.

This case also had the element of lack of informed consent. Documenting that informed consent occurred is also part of the medical record and one could argue if the medical record was complete, that would mean informed consent was documented. The veterinarian argued that she had multiple conversations with this owner regarding the risks, but they were not documented.

Cases #10-10 and #10-12, published July-August 2011

"Failure to create and/or maintain appropriate veterinary medical records for the prescribing, sale and dispensing of pharmaceuticals."

A record of prescribing and dispensing of pharmaceuticals is considered part of the medical record. Proper documentation of prescribing and dispensing includes documentation of the existence of a VCPR, documenting the relevant medical information that establishes the need for the prescription, and documenting that proper dispensing practices are followed. These records are expected of all members.

Case #10-17, published July-August 2011

"Failed to create and/or maintain proper medical records with respect to the kitten."

There was a medical record created in this case. The veterinarian presented the argument that he thought something was suspicious about the man who presented this kitten, so he did not write much down. Members should be aware of cases that are unusual and pay extra attention to detail of the medical record. Take the extra time to go the extra mile to document clearly the exam findings, differential diagnoses, treatment plan and all client communications.

Cases #10-18 and #10-19, to date,not yet published

"That you failed to maintain proper, appropriate and legible records with respect to the veterinary medical services provided to the dog."

These cases have been referred to a hearing. The Notice of Hearing contains the above allegation of failure to maintain a medical record but the hearing has not taken place as of yet.

Case #10-25, published September-October 2011

"That the veterinarian failed to create or maintain appropriate medical records with respect to the dog."

The medical records were computerized and had a couple of case summaries but failed to provide a logical description or timeline of the progression of this case. If the explanation that the veterinarian provided to the CRC during consent discussions had been in the medical record when the case was first referred, this case may have been dismissed. This was a complicated case requiring several surgeries and a lot of client communication with a difficult client. If every single procedure that was performed and all decisions and communication had been recorded, this case may have been dismissed.

2011

In 2011 there were 25 formal complaints received; 7 cases were referred for a hearing by the Complaint Review Committee. In all cases, there was one or more allegation pertaining to the medical records.

Case # 11-01, published September – October 2011

"That the veterinarian failed to record in the narcotics log the doses of hydromorphone administered to the cat during the period December 28-30, 2010."

"That the veterinarian failed to maintain appropriate veterinary medical records with respect to the cat."

The veterinarian simply did not have a complete narcotics log and suggested that he has a busy practice and did not have the support staff or the time to complete it appropriately. The medical record did not document the medical management of the case. CRC noted that the physical exam findings were the default to normal descriptions, including the description of a normal abdomen when in fact the cat had a distended bladder with blood coming from the urethra.

Case # 11-02, published January-February 2012

"That the veterinarian failed to create or maintain proper medical records with respect to the dog."

"That the veterinarian failed to properly manage the handling, storage and record of use with respect to controlled substances in the clinic, in particular, the "stock bottle" of BAA in use from June 2010 to February 2011."

The medical record did not document who gave the injection of the pre-anesthetic medication. There was no record of anesthetic monitoring, especially during the recovery, given the complication of collapse following administration of the pre-anesthetic.

There was no registry in the narcotics log of the butorphanol that was contained in the premixed bottle of BAA. All narcotics must be accounted for in clinic acquisition and use logs, including that in the premix bottles if such bottles are in use.

Case # 11-03, published January – February 2012

"That the veterinarian failed to create or maintain acceptable veterinary medical records with respect to the cat."

Comment from CRC was that there was no legitimate record of the treatment provided, and what was there was not legible. The CRC could not determine which blood tests were performed and when. There was no record of communication with the owner at discharge. A sick cat was sent home without any information on what to expect or how to proceed. As a result, the owner did not follow up with the veterinarian and the cat was ultimately euthanized.

Case # 11-15, published January – February 2013

"That the veterinarian failed to maintain appropriate and legible veterinary medical records with respect to the veterinary medical services provided to the dog."

This case had a medical record that needed to be transcribed in order for the committee to determine what was written. There is a requirement in the bylaws that the records be legible.

Case # 11-20, published January – February 2013

"That you failed to maintain appropriate and legible veterinary medical records with respect to the treatment of the dog."

"That you altered the dog's medical record by deleting the original owner's name."

"That you failed to document discharge instructions regarding the dog."

"That you failed to document client communications regarding the dog."

There are several allegations here. The medical record is never to be permanently changed so that information previously contained cannot be read. If an animal changes owner, the previous owner's name must be maintained in the medical record. There was an issue with respect to the diagnostic tests that were performed without recording that the test was performed. There was no record of any communication with the client.

Case # 11-22, published July – August 2012

"That the veterinarian failed to maintain appropriate and complete medical records with respect to the cat including:

"The veterinarian failed to maintain an appropriate detailed anesthetic record."

This cat was administered an inadvertent injection of euthanyl and while it was anesthetized, there was no record of any monitoring activity.

Case # 11-25, published March – April 2013

"That the veterinarian failed to maintain complete, appropriate and/or accurate medical records with respect to the dog."

"That the veterinarian failed to create medical records with respect to the dog on a contemporaneous basis."

"That the veterinarian failed to maintain appropriate and complete medical records regarding the dog, including an anaesthetic record."

"That the veterinarian altered and/or amended the medical records relating to the dog subsequent to events recorded."

The medical record was permanently altered by the veterinarian and were not completed on a contemporaneous basis. The reason provided was that the dog had been sold to a new owner. There were inconsistencies between the copies of the medical records.

Acknowledgments:
Drs. Jen Willans, Colleen Pratt, Jack Wilson, Cary Hashizume, Ken Keeler, Louis Kwantes, Jocelyn Forseille, Randy Killeen and Ms. Nichole Boutilier

ABVMA PIPS Bylaws

PIPS 2012 Quality Assurance Self -Verification Guide

PIPS TIPS on Medical Records

Informed Consent Articles:
Deputy Registrar's Report Member's Magazine Nov-Dec 2002
Registrar's Report Member Magazine May-Jun 2008

Privacy and Information Management – ABVMA Member Website

Guideline Medical Records for Companion Animals – College of Veterinarians of Ontario (CVO)

Veterinary Medical Records – Dr. Harmon Rogers, WSU

Sample Medical Record Forms

FLUID MONITORING SHEET

Animal ID:	Client:
Fluid Types:	Additives:
Micro:	Macro:

1st Rate:	Ml/24h	Drops/min_____ Date:_____
2nd Rate:	Ml/24h	Drops/min_____ Date:_____

Time	Calculated	Actual	H.R.	Urine	PCV	Misc.

Anesthesia Record

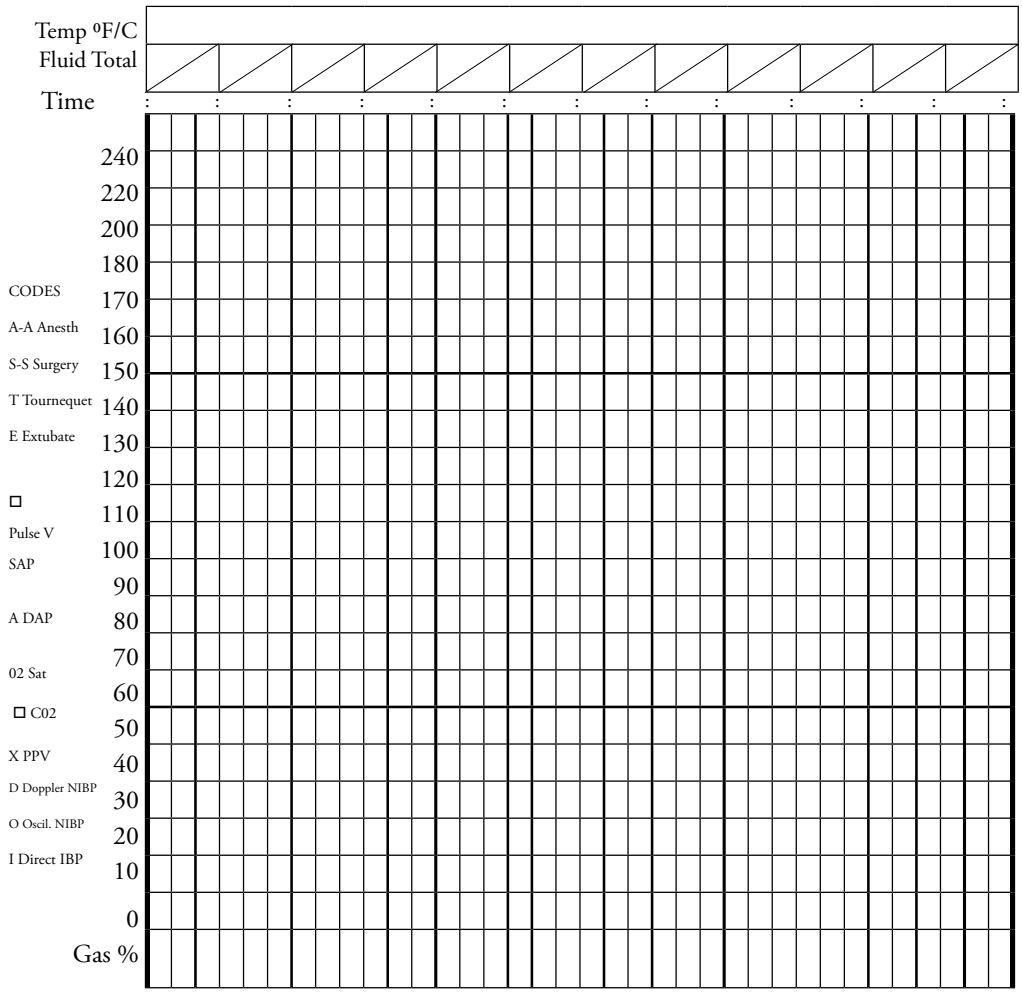
Date: _____

Please X all meds when given

E Sheet Printed? Yes ❑ No ❑

Client Animal	Surgeon	Anesthesia Technicians	Procedures
Body Weight Kg._____Lbs._____	MM Color/CRT/Pulse	Physical Status E G F P C	
Species	Age/Sex	Mental Status	Lab Tests – List pertinent abnormalities below
Premed Drugs, Dose, Route, Time		Premed Effect Ramsay Sedation Score 1 - 2 - 3 - 4 - 5 - 6 Did patient vomit? YES ❑ NO ❑	
Induction Agent	Amount Drawn Up	Route	Unused Amount
Drug, Dose, Route, Time	Drug, Dose, Route, Time	Drug, Dose, Route, Time	Drug, Dose, Route, Time
Inhalant use - Isoflurane / Sevoflurane / None	Inhalant System Adult Circle / Ped Circle / Bain W/Block	Reservoir Bag Size	ET Tube Size
IV Catheter Size	IV Fluid Type	Total Fluids Given	Comments/Alerts
Total # Used			

Notes



Recovery Notes	T, P, R	MM, CRT	Post OP Meds/Dose/Time Pain Sedation Scores Completed By:

See Other Side For Pain and Sedation Scales

AB.VMA Alberta Veterinary Medical Association

NATIONAL INSTITUTES OF HEALTH

WARREN GRANT MAGNUS CLINIC CENTRE

PAIN INTESTITY INSTRUMENTS

JUL - 03

Modified FLACC Scale							
DATE/TIME							
Face							
0 - No particular expression							
1 - Occasional grimace, withdrawal, disinterested							
2 – Frequent grimace, clenched jaw							
Legs							
0 – Normal position or relaxed							
1 – Uneasy, restless, tense							
2 – Kicking, or legs drawn up							
Activity							
0 – Lying quietly, normal position, moved easily							
1 – Squirming, shifting back and forth, tense							
2 – Arched, rigid or jerking							
Cry							
0 – No cry, whine (awake or asleep)							
1 – Moans or whimpers; occasional yipes							
2 – Crying steadily, screams, frequent yipes							
Consolability/Stress							
0 – Content, relaxed							
1 – Reassured by occasional touching, hugging or being talked to, distractible							
2 – Difficult to console or comfort							
TOTAL SCORE							

RAMSAY SEDATION SCALE							
1 – Patient anxious, agitated, restless							
2 – Patient cooperative, oriented, tranquil							
3 – Patient responds to commands only							
4 – Brisk response to light gabellar tap or auditory stimulus							
5 – Sluggish response to light gabellar tap or auditory stimulus							
6 – No response to the stimulus mentioned in items 4 and 5							

CALF ADMISSION SHEET

OWNER:	SPECIES/BREED:		
ADDRESS:	COLOUR/GENDER:		
TELEPHONE HOME:	BIRTHDATE:		
TELEPHONE WORK:			
EAR TAG/ID:	DAM:	HEIFER:	COW:

HISTORY

Calving Ease:			Unassisted:			Slight Assist:	
COLOSTRUM::			Nursed: Y ❑ N ❑			# Hours afterbirth:	
			Commercial Product:			Quantity:	
Vacc'n Hx of Dam	IBR	BVD	BRSV	P13	HS	E-coli	RC
Electrolytes	Type:						
	Quantity:						
First Defence			Colimune				
Selenium			Calf-Guard				
Vitamin AD			Antibiotics			Dose	
Response to treatment							

Presenting Complaint

# Calves affected	Trt	Response	
ADMISSION EXAM	T	P	R
DVM ASSESSMENT / TREATMENT PLAN			
ATTENDING DVM			

I hereby authorized (insert clinic name) to perform the following procedures on the above described animal. I understand the procedure, or it has been explained to me and as the legal owner or responsible party, I accept financial responsibility.

DATE:	ADMITTED BY:	OWNER SIGNATURE:
TIME:		

CANINE GENERAL PHYSICAL EXAMINATION PROTOCOL

Obtain the animal's weight and assess the following: Head:

- ❑ The dog's head is visually assessed for symmetry, ocular lesions or discharges, skin lesions, nasal deformities or discharges and deformities or discharges relating to the mouth.
- ❑ The pinne are manipulated for facilitating gross visualization of the internal surface and the external auditory canal. Otoscopic exam is only performed where there is evidence of debris in the auditory ear canal or the client has described symptoms suggesting an otoscopic exam is necessary (i.e. scratching, shaking, odour, head tilt).
- ❑ Eyes are not examined with an opthalmoscope unless symptoms or history dictate that it is necessary. Eyes are assessed for colour, position, and visible lesions only. The pupillary light reflex is only assessed when gross examination findings or history suggest the possibility of visual impairment.
- ❑ The lip is lifted on each side to visualize the dentition and gum colour. Capillary refill time is assessed by applying digital pressure to the gum surface dorsal to one of the maxillary canine teeth. The lips are digitally retracted to assess the labial surfaces of molars and pre-molars unless the patient is sufficiently aggressive to put the examiner at risk of being bitten. Where safety permits, the mouth is opened for visual assessment of the tongue, palate, and mesial surfaces of all teeth. The mouth is inspected for the presence of foreign bodies, decaying teeth, tartar accumulation, and odours. The tongue is not routinely retracted or depressed unless the history or other findings suggest this is necessary.

Neck, Chest, Abdomen:

- ❑ The neck is visually assessed and palpated only. It is not routinely manipulated unless history or other signs suggest this is necessary. The neck is assessed for skin lesions including growths, swellings, or injuries. The coat is assessed for texture and signs of abnormal hair loss. The vertebrae are assessed for any irregularities in shape.
- ❑ The chest is assessed visually and palpated for skin lesions including growths, swellings or injuries, irregularities of the ribs and vertebrae including abnormalities in shape, and the coat is assessed for texture and signs of abnormal hair loss. The chest is auscultated on both sides with a stethoscope. The heart is assessed for rate, rhythm and the presence of murmurs which, if present are graded on a scale of 1 to 6. The lungs are assessed for respiratory rate (unless panting) and signs of wheezing, crackles, or other stertour.
- ❑ The abdomen is visually assessed and palpated including an attempt to perform a deep palpation of the dog's internal organs unless the patient is overly tense, preventing any meaningful palpation. Deep organ palpation includes, where possible, the liver, kidneys, and bladder as well as an attempt to screen for the presence of any abnormal internal masses. The lumbar vertebrae are palpated for irregularities in shape. The skin is assessed for any lesions, growth, swellings or injuries and the coat is assessed for texture, signs of abnormal hair loss and is separated over the lumbar area and tail head to screen for evidence of parasites (fleas).

Tail and Legs:

- ❑ The tail and legs are visually assessed and palpated for evidence of skin lesions including growths, swellings or injuries, irregularities in shape of the bones and vertebrae, and the coat is assessed for texture and signs of abnormal hair loss. Individual limbs are not assessed further unless the history or other clinical signs suggest a need to do so. Further assessment of the limbs might include, where necessary, manipulation of joints to screen for crepitus or pain, neurological placement tests, assessment for luxating patella or assessment for anterior drawer of the stifle.
- ❑ The examination concludes with dorsal manipulation of the tail for insertion of a rectal thermometer and measurement of core body temperature. Digital rectal exam is not routinely performed unless the history or other clinical signs suggest a need to do so. If performed, a digital rectal exam is used to assess the rectum for lesions, growths or surface irregularities, prostate in the male for swelling, pain or asymmetry and the anal sacs for impaction. If the anal sacs feel distended and there is a history of clinical signs consistent with anal sac impaction (scooting), they may be digitally expressed at this time with the client's consent.

PRIVACY AND INFORMATION MANAGEMENT

Client Health Consent Form

NOTE TO CLIENT:

We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you and your pet/animal. If you have a question on any of this, please ask.

CONSENT FOR TREATMENT: [Insert your usual consent for treatment provisions here.]

_____

_____

_____

CONSENT FOR THE COST OF OUR SERVICES: [Insert your usual financial provisions here.]

_____

_____

_____

CONSENT FOR PERSONAL INFORMATION:

- I understand that to provide me with veterinary goods and services, [ABC Veterinary Hospital] will collect some personal information about me (i.e.: [set out some common examples like home telephone number, address]).
- I have reviewed the [ABC Veterinary Hospital]'s Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.
- I understand that only if I check off the following boxes will I receive the following: [insert opt-in clauses where opt-out consent would not be appropriate].
- I would like to receive notice when it is time to review whether I need new goods or services.
- I would like to receive newsletters and other informational mailings from [ABC Veterinary Hospital].
- I would like to receive notice of promotions and special offers from [ABC Veterinary Hospital].
- I would like to receive newsletters and other informational mailings and notice of promotions and special offers from other organizations that [ABC Veterinary Hospital] thinks might be of interest to me.
- I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.
- I agree to [ABC Veterinary Hospital] collecting, using and disclosing personal information about me as set out above and in the [ABC Veterinary Hospital]'s Privacy Policy.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

NOTES MADE BY [ABC Veterinary Hospital]: _____

_____

_____

_____

CLIENT INFORMATION SHEET

Name:
Address:
Address 2:
Residence Phone:
Business/Workplace Phone:
Cell Phone:
Email:
Transmission of confidential information? Y ❑ N ❑

Alternate Contact
Name:
Address:
Residence Phone:
Business/Workplace Phone:
Cell Phone:
Consent to act as Client's Agent: Y ❑ N ❑
Client's Signature:

CLIENT REGISTRATION FORM

Client	
Name:	
Address:	
Residence Phone:	Business Phone:

Patient Information		
Name:		
Dog:	Cat:	Other:
Breed:	Colour:	
Birth Date:	Sex: M❑ F ❑	
Tattoo:	Microchip:	
Markings:		

Previous Veterinarian
Name of Veterinarian:
Confirmation to request files: Y ❑ N ❑
Last Treatment(s):
Any known drug allergies:
Prior illness/surgery:
Medications:
Diet restrictions/supplements:
Reason for initial visit:

_____ , DVM Date:_____

COMPLEMENTARY AND ALTERNATIVE VETERINARY MODALITY(S)

CLIENT CONSENT FORM

1. OWNER IDENTIFICATION: Date: _____

Name:_____

Address: _____

Phone: _____

2. ANIMAL'S DESCRIPTION:

Animal's Name or Identification No. _____

Breed _____ Age _____

3. INFORMATION PROVIDED:

i. I have been advised by Dr(s). _____ of the conventional, complementary and alternative veterinary options for diagnosis and therapy for my animal, and their associated risks, costs and prognosis.

ii. I am aware that the following complementary and alternative modalities to be used in the treatment of my animal are not considered conventional veterinary medicine.

N _____

N _____

N _____

4. I AGREE THAT:

i. I have read and fully understand this Client Consent Form

ii. I am the owner of, of the authorized agent of, the animal described above and I am of legal age (18 years or older)

iii. I consent to the provision of the above listed complementary and alternative modalities for my animal by the above-mentioned doctor(s)

iv. I am the seeking complementary or alternative services without involvement of my veterinary practitioner.

_____

Client Signature

_____

Veterinarian Signature

_____

Witness Signature

CONSENT TO PERFORM DIAGNOSTICS, MEDICAL TREATMENT, SURGERY OR ANCILLARY SERVICES

CONSENT
Client:
Contact Telephone Number:
Alternate Contact Number:
Animal ID:
Species:
Breed:
Colour:
Sex:
Procedure(s):

1. I am the owner or agent of the animal described above. I have authority to execute this consent and am over the age of 18.
2. I hereby consent to and authorize the performance of the above described procedure(s). I understand the risks that may be involved.
3. I have had the fees outlined to me and agree to pay all such fees and charges at the time of discharge unless alternate financial arrangements have been made prior to discharge.
4. If unforeseen conditions arise which, in the judgment of the attending veterinarian, call for procedures or treatments other than those now being authorized, I authorize such procedures if reasonable efforts to contact me for further consent are unsuccessful.
5. If unforeseen conditions of an urgent or emergency nature arise that, in the judgment of the attending veterinarian, call for procedures or treatments other than those now being authorized, I authorize the performance of such procedures if you are unable to contact me for further consent at the time.
6. I have read and understand this consent.

_____ _____

Signature of Owner / Agent **Date**

CONTROLLED SUBSTANCE LOG
(ACQUISITIONS)

DATE	PRODUCT	INVOICE	LOT NUMBER	PRODUCT NAME	SIZE	BOTTLE ID#	INITIAL DVM (OUT)

CONTROLLED SUBSTANCE LOG

(OPEN DRUG CONTAINER INVENTORY (ODCI)

DRUG NAME:	FORMULATION	STRENGTH	SIZE	BOTTLE ID#

DATE	OWNER IDENTIFICATION	PATIENT NAME	DRAWN	USED	BALANCE ON HAND	DISPENSING DOCTOR

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CONTROLLED SUBSTANCES REGISTER

NAME OF DRUG:		FORM:		STRENGTH:		SIZE:
DATE	FULL NAME OF CLIENT & ADDRESS	ANIMAL ID	SIGNATURE OF PERSON USING	AMOUNT USING	STOCK ADDED	BALANCE

DISCHARGE SUMMARY SHEET

Animal ID: _____ **Client:** _____

Diagnosis:
Treatment/Tests:
Medications:
Exercise:
Dietary Directions:
Recheck Date:
Doctor:
Additional Instructions:

_____ , DVM Date: _____

EUTHANASIA AUTHORIZATION

CLIENT ID: _____

CLIENT NAME: _____

ADDRESS: _____

_____

CITY/PROV: _____

POSTAL CODE: _____

TELEPHONE: _____

PATIENT ID: _____

NAME: _____

SPECIES: _____

BREED: _____

SEX: _____

COLOR: _____

MARKINGS: _____

BIRTH DATE: _____

*If different from Owner:

AGENT ID: _____

AGENT NAME: _____

ADDRESS: _____

CITY/PROV: _____

POSTAL CODE: _____

TELEPHONE: _____

- I, the undersigned, am the owner/duly authorized agent for the owner of the animal described hereon. I verify that said pet has not bitten any person or animal during the last ten (10) days and to the best of my knowledge has not been exposed to rabies. I hereby consent to and order euthanasia (humane death) to be performed on this animal forever releasing said doctor and his agent from any and all liability for performing euthanasia.
- It is my desire to provide for my pet decent and humane after-death care, complying with all legal requirements of the area. I authorize the attending veterinarian to now dispose of the remains in accordance with hospital policy, releasing the hospital, doctor, and agents from any and all liability for performing said after-death care, with the following stipulations included:
- Requested method of aftercare:

_____

_____

Owner/duly authorized Agent: _____

Signature _____ Date _____

Veterinarian: _____

Signature: _____

EXAMINATION TEMPLATE

Client:	Animal ID:	Date:	Time:

SPECIAL NOTES:

Presenting Complaint:

Frequency & Duration:

Previous treatment of problem:

Response to treatment:

SUBJECTIVE FINDINGS:

Appetite:	❑ Norm ❑ Abn ❑ N/A	Drinking:	❑Norm ❑Abn ❑ N/A	Coughing:	❑ Norm ❑ Abn ❑ N/A	Sneezing:	❑ Norm ❑ Abn ❑ N/A
Attitude:	❑ Norm ❑ Abn ❑ N/A	Vomiting:	❑ Norm ❑ Abn ❑ N/A	Bowels:	❑ Norm ❑ Abn ❑ N/A	Urination:	❑ Norm ❑ Abn ❑ N/A

Notes:

OBJECTIVE FINDINGS:

TEM	HR	RR	MM	CRT	Wt

1. Adbomen/Palpation:
❑ Norm ❑ Abn ❑ N/E

2. Ears:
❑ Norm ❑ Abn ❑ N/E

3. Eyes:
❑ Norm ❑ Abn ❑ N/E

4. Heart:
❑ Norm ❑ Abn ❑ N/E

5. Integument:
❑ Norm ❑ Abn ❑ N/E

6. Lymphatic:
❑ Norm ❑ Abn ❑ N/E

7. Musculoskeletal:
❑ Norm ❑ Abn ❑ N/E

8. Neurological:
❑ Norm ❑ Abn ❑ N/E

9. Oral Cavity:
❑ Norm ❑ Abn ❑ N/E

10. Respiratory
❑ Norm ❑ Abn ❑ N/E

11. Urogenital
❑ Norm ❑ Abn ❑ N/E

12. Body Condition
❑ Norm ❑ Abn ❑ N/E

NOTES:

HISTORY:

ASSESSMENT / DX:

PLANS / TREATMENT:

RECOMMENDATIONS / INSTRUCTION TO OWNER:

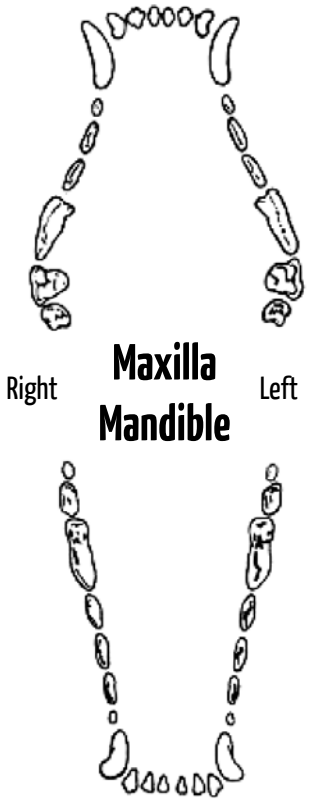
DVM: _____ **DATE:** _____

EXTERNAL LABORATORY TRACKING LOG

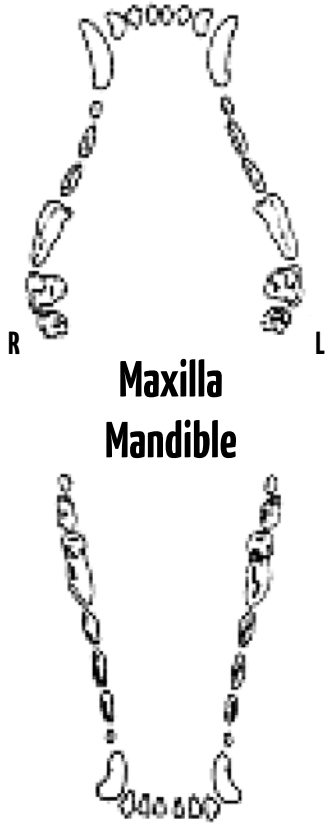
Client Animal ID	Species	Test (s)	Dr.	Drop Off Date	Initial	Courier & Date Sent	Results Rec'd	Client Advised

Notes:

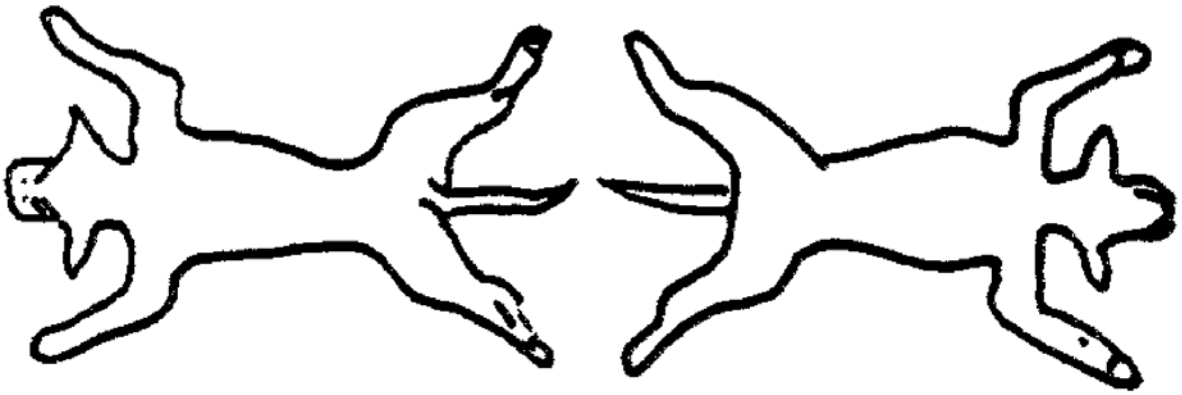
EYE / DENTAL / DERMATOLOGICAL TEMPLATE



CANINE



FELINE



EYE / DENTAL / DERMATOLOGICAL TEMPLATE /2

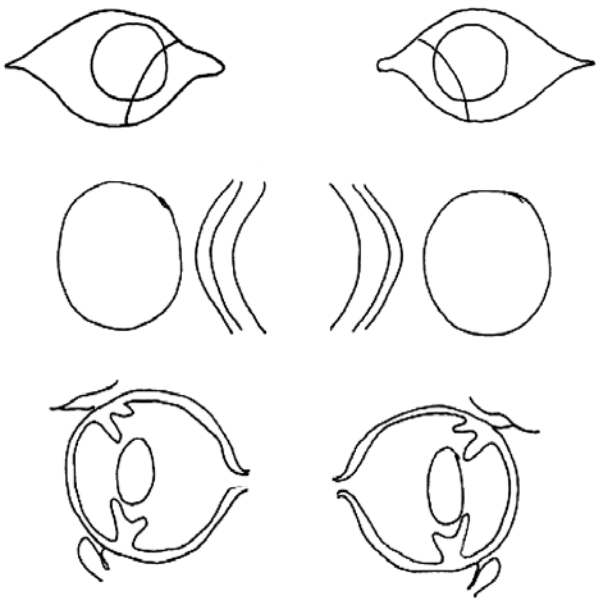
Date: _____

Client: _____

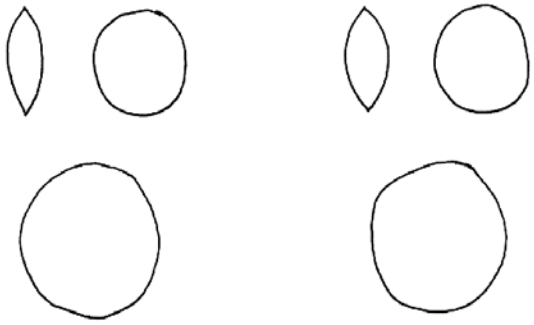
Animal ID:_____

	OD (RIGHT)	OS (LEFT)
MENACE		
PALPEBRAL		
PLR DIRECT		
PLR CONS.		
STT		
FLUORESCEIN		
DISCHARGE		
IOP		

OD OS



A P A P



FARM ANIMAL MEDICAL RECORD

OWNER ID:
DIRECTIONS:
HERD INFO:
SPECIES:
BREED:
/ TYPE OF ANIMALS:

Date	Description	Initial

Date	Description	Initial

FARM VISIT REPORT | VETERINARY ANIMAL HEALTH

Feedlot:

Fax:_____

Cattle Examined at Necropsy

Date	Lot ID	CCIA Tag#	Pathology	Diag'tic Code

Live Cattle Examined: _____ **Date:** _____

Pen	Tag ID	Diagnosis	Comment

Advice Given or Ensuring Discussion:

Veterinarian: _____

IN-HOUSE LABORATORY TRACKING LOG

Client Animal ID	Species	Test (s)	Dr.	Drop Off Date	Initial	Courier & Date Sent	Results Rec'd	Client Advised

Notes:

MASTER PROBLEM LIST

Animal ID:	Client:
Species:	File #:
Birth Date:	Breed:
Neutered: YES ❑ NO ❑	Sex: Male ❑ Female ❑

Warnings (e.g. drug allergies, behaviour problems, etc.)

_____

Ongoing Medications:

_____

Procedures		Date											
Vaccinations													
FeLV/FIV (+/-)													
HWT													
Intestinal Parasites													
Weight (kg)													

Procedures	Date	Treatment	Diagnostics

MEDICAL RECORD TRANSFER REQUEST

Date: _____

I the undersigned, am the owner/duly authorized agent for the owner of the animal described hereon.

I authorize the release of the information contained in the medical records for this animal from:

_____(Veterinary Clinic)

to:

_____ (Name)

_____ (Address)

_____ (Phone)

_____ (Fax)

Patient Name: _____

Owner/Duly Authorized Agent (Print _____

Signature of Owner/Duly Authorized Agent:

Please Fax record to (____) _____ - _____

Thank-you.

PROGRESS NOTES

Last Vaccination: (What, Where When)	
Previous History:	

DATE	SOAP		INITIAL

PROGRESS NOTES

DATE	SOAP		INITIAL

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RADIOLOGY LOG

DATE	ANIMAL I.D.	CLIENT	BREED	AREA OF BODY	BODY THICKNESS	K.V.	M.A.	TIME	COMMENT

SAMPLE ABBREVIATION LIST

Ab	Antibiotics
BAR	Bright, alert and responsive
CNL	Cavitary neck lesion
CRT	Capillary refill time
DDX	Differential diagnoses
FX	Fracture
FUO	Fever of unknown origin
GPE	General Physical Examination
HAC	Hyperadrenocortism
HBC	Hit by car
INB	If no better
INI	If no improvement
LMOM	Left message on machine
NAF	No abnormal findings
NSF	No significant findings
O	Owner
QAR	Quiet alert responsive
R/o	Rule out
RX	Prescription
SID	1 time daily
BID	2 times daily
TID	3 times daily
q4h	Every 4 hours
SX	Surgery
TC	Telephone call
TDX	Tentative diagnoses
TX	Treatment
WCB	Will call back
WNL	Within normal limits

SAMPLE EQUINE EXAMINATION PROTOCOL

REPRODUCTIVE ORGAN EXAMINATION IN THE MARE

Utilized by: Dr. _____

Dates Utilized: (i.e. 2003-present) _____

Reference:

Journal / Text: _____

Title: _____

Page(s): _____

Method:

The mammary system is palpated for evidence of mastitis, abscessation, neoplasia or injury. The mare's perineal area is washed and disinfected and the tail wrapped prior to examination. The vulva is examined for conformation, apposition, tone and evidence of discharge. Poor conformation of the vulvar lips and vulva are noted where they may predispose the mare to problems like pneumovagina and fecal contamination of the vagina. The vulvar lips are separated to detect any evidence of passage of air into the vagina.

The examination continues to the clitoris and clitoral fossa. Where contagious equine metritis (CEM) is suspected, the clitoral sinuses are cultured.

Rectal palpation is performed to assess the ovaries for size and structures that may be present including corpora lutea, follicles and cysts. The ovulation fossa is examined for evidence of ovulation and the pelvis is palpated for any structures that might interfere with breeding or parturition.

The cervix is palpated per rectum and assessed for length, turgour and the presence of any abnormal structures.

Veterinarian's Signature: _____
Date: _____

SAMPLE EQUINE MEDICAL RECORD

Date: _____ Veterinarian: _____

Owner:_____

Animal Identification: _____

History / Previous Treatment

.....

.....

.....

.....

Presenting Complaint

.....

.....

.....

.....

Physical Examination

T: _____(F/C) HR:_____ bpm RR: _____/min

Attitude:_____ BCS _____

Appetite: Normal / Partial / Absent Duration_____

Significant Findings:

.....

.....

.....

.....

.....

.....

.....

Assessment

Treatment Plan

Instructions to Owner

Product	Amount	Route	Frequency	Duration

Withdrawal Instructions

Veterinarian's Signature: _____ **Date:** _____

SAMPLE EQUINE SURGICAL PROTOCOL
EQUINE ANESTHESIA FOR CASTRATIONS & OTHER FIELD PROCEDURES

Utilized by: Dr. _____

Dates Utilized: (i.e. 2003-present) _____

Reference:

Journal / Text: _____

Title: _____

Page(s): _____

Method

Pre Anesthetic evaluation

The horse's body condition is evaluated and scored on the Henke scale. The heart and lungs are ausculted, listening for arrhythmias and the horse's temperature is taken unless the horse is excessively anxious or untrained. Castrations are done under general anesthesia as follows.

Anesthetic Protocol:

Xylazine (0.5 mg/ lb) + butorphanol (0.01 mg/lb) given intravenously, mixed in the same syringe: the horse is kept quiet during this procedure. Restraint techniques such as twitches are avoided unless absolutely necessary. Adult stallions are given 5 ml of xylazine (100 mg/ml) and 1 ml of butorphanol (10 mg/ml).

Within 2 - 5 minutes the horse's head relaxes and drops below the level of its withers. If this does not occur, another dose of xylazine (0.1-0.2 mg/lb) is administered.

After sedation is achieved, ketamine (1 mg/lb) and diazepam (0.02 mg/lb) are administered by slow intravenous injection mixed in the same syringe.

When the horse becomes recumbent it is positioned in left lateral recumbency, the eyes are covered with a towel and the upper leg is tied forward out of the way.

The spermatic cord of each testis is injected with 10-15 mls of mepivicaine or lidocaine. The horse is then scrubbed and castrated, using the technique described in [cite text reference].

Tetanus toxoid vaccination and procaine penicillin (300,00 iu/ml) at a dose of 5 mil/1 00blbs are administered during anesthesia.

During surgery the patient's palpebral reflex, eye position, respiratory pattern, rate and amplitude and heart rate are assessed.

Following completion of the procedure the horse is allowed to recover with minimal stimulation. If it demonstrates nystagmus, the horse is prevented from rising by holding the head so that the nose is elevated approximately 90 degrees to the ground. When ready, the horse is permitted to attain sternal recumbancy for a minute, and then allowed to stand after which it has a handler at its head for 10-15 minutes before being moved or transported.

SMALL ANIMAL RECORD

CLIENT ID:	PATIENT ID:
CLIENT NAME:	NAME:
ADDRESS:	SPECIES:
CITY/PROVINCE:	BREED:
POSTAL CODE:	SEX:
TELEPHONE:	COLOUR:
E-MAIL:	MARKINGS:
	BIRTHDATE:

**If different from owner	
AGENT ID:	
AGENT NAME:	
ADDRESS:	
CITY/PROVINCE:	POSTAL CODE:
TELEPHONE:	

WELLNESS CHECKLIST	DATE DVM												
DA2PPC													
BORDETELLA													
PARVOVIRUS													
PCRC													
FELV													
RABIES													
TAG#													
FECAL													
DEWORM													
HEARTWORM TEST													
HTWM PREVENTION													
WEIGHT													

SMALL ANIMAL RECORD

DATE	#	PROBLEM LIST	WT	MEDICATIONS	REFILL	DVM

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SURGERY / ANESTHETIC LOG

DATE	RISK	PATIENT ID	SEX	BREED	WT (kg)	PROCEDURE	PRE-ANES	USED.	INDUCT'N	USED.	MAINTENANCE	AN AL	SURG TIME	ANES TIME	DVM AHT

_____ , DVM DATE:_____

SURGERY / ANESTHETIC MONITORING SHEETS

Date:_____

Client:		Animal ID:	
Species:	Breed:	Age:	Weight:
Procedure:			
Surgeon:		Assistant:	
Pre-Anesthetic Agent:		Dose:	Route:
		Dose:	Route:
Pre-Op Status:		Post-Op Status:	
E.T.T. Size:		Cuffed ❑	Non Cuffed ❑

	Minutes											
	0	10	20	30	40	50	60	70	80	90	100	110
U/m in Oxygen												
[insert name] %												
[insert name] %												
R.P.M												
Heart Rate B.P.M												
Comments:												

Pre-Op:

C1 = healthy
C2 = mild disease/old
C3 = severe disease but basically healthy
C4 = anesthetic/surgery risk

Post-Op:

P1 = normal recovery
P2 = more vocalization then normal, excessive paddling
P3 = extreme vocalization, convulsions, vomiting
P4 = cardiac/respiratory arrest

SURGICAL PROTOCOLS

(where empty spaces are indicated in **Method** section, please insert name)

Canine Castration

Utilized by: Dr. _____

Dates Utilized: (i.e. 2003-present) _____

Reference:

Journal / Text: _____

Title: _____

Page(s): _____

Method (insert name in spaces)

After anesthetic induction the dog is placed in dorsal recumbency and the area just cranial to the scrotum is carefully clipped using a 40 blade. The area is scrubbed using [insert name] scrub and then prepped for surgery using _____.

The dog is carried into the surgery room and placed in dorsal recumbency on the surgery table.
The open technique from the reference is used. There is a variation in the closure; the subcutaneous tissue is closed with [insert name] in a simple continuous pattern. The skin is closed with_____in a continuous subcuticular suture pattern.
Any variations to the above format will be recorded in the patient's medical records.

SURGICAL PROTOCOLS

(where empty spaces are indicated in **Method** section, please insert name)

Ovariohysterectomy – routine immature cat

Utilized by: Dr. _____

Dates Utilized: (i.e. 2003-present) _____

Reference:

Journal / Text: _____

Title: _____

Page(s): _____

Method (insert name in spaces)

The cat is anesthetized and the bladder manually expressed of any urine. The ventral abdomen is clipped and surgically prepped 3 times with_____scrubs, alcohol and a final_____swabbing. A ventral midline skin incision is made with a #10 scalpel blade starting approximately 3 cm caudal to the umbilicus and extending caudally 3-4 cm. The subcutaneous tissues are incised and separated from the external fascia. The linea alba is incised with scissors after an initial nick with a #10 scalpel blade. The right uterine horn is retrieved with the spay hook and with gentle tension the right ovary is held while the suspensory ligament is stretched and/or broken. A triple clamp technique is used on the ovarian pedicle and a ligature of _____is placed. The procedure is repeated with the left ovary. The uterine body is exteriorized with the broad ligament broken. A _____ ligature is placed on the uterine body just above the cervix. All pedicles including the uterine stump are held with Adson forceps to check for bleeding prior to releasing them into the abdomen. The linea alba is closed with_____in a simple interrupted pattern. The subcutaneous tissues are closed with_____ in a similar continuous pattern. Skin closure is by means of a simple interrupted pattern using_____.

SURGICAL PROTOCOLS

(where empty spaces are indicated in **Method** section, please insert name)

Ovariohysterectomy – routine mature cat

Utilized by: Dr. _____

Dates Utilized: (i.e. 2003-present) _____

Reference:

Journal / Text: _____

Title: _____

Page(s): _____

Method

The procedure is identical to that described for the immature cat except that ovarian pedicles may be double ligated and the uterine vessels may be ligated separately if prominent. The abdominal closure is described above.

SURGICAL PROTOCOLS

(where empty spaces are indicated in **Method** section, please insert name)

Ovariohysterectomy – routine immature dog

Utilized by: Dr. _____

Dates Utilized: (i.e. 2003-present) _____

Reference:

Journal / Text: _____

Title: _____

Page(s): _____

Method (insert name in spaces)

The dog is anesthetized and prepped as described for the immature cat. A ventral midline incision is made with a #10 scalpel blade starting approximately 1 cm caudal to the umbilicus and extending caudally approximately 4-8 cm depending on the size of the dog. The subcutaneous tissues are incised with the scalpel and elevated off the external fascia by means of blunt dissection. A nick incision is made in the linea alba while it is held elevated. The incision in the linea alba is extended with Mayo scissors. The ovarian pedicles are exteriorized and ligated in the manner previously described for the immature cat. The pedicles are ligated with _____ _____. The pedicles are inspected for bleeding prior to release into the abdomen. The uterine body is exteriorized as previously described and ligated with a suture of _____. The linea alba is closed with a simple interrupted suture pattern using _____for dogs weighing less than 5 kg and _____ for dogs greater than 5 kg in weight. The subcutaneous tissues are closed with a simple continuous pattern using _____ for dogs weighing less than 5 kg and _____ for dogs weighing more than 5 kg. The skin is closed with an interrupted pattern using _____ sutures.

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SURGERY / ANESTHETIC LOG

DATE	CLIENT / ANIMAL ID	BREED	AGE / SEX / WEIGHT	PROCEDURE	CONDITION		ANESTHETIC REGIMES PRE – INDUCTION – MAINTENANCE			Other	TIME (min)		Dr. Initials
					Pre-Op C 1-4	Post-Op P 1-4	Pre-Anesthetic Name/Dose/Route	Induction Anesthetic Name/Dose/Route	Maintenance Anesthetic Name/Dose/Route		Anes.	Surg.	

Drug Code:

Condition Code:

C1 = Healthy
C2 = Mild Disease (e.g. Otitis)
C3 = Severe Disease but basically healthy (e.g. pyometra, uremia)
C4 = Anesthetic and Surgery Risk (severe underlying disease)

Post-Op Code:

P1 = Normal recovery
P2 = Vocalization, Excitement, Paddling
P3 = Extreme Vocalization, Convulsion, Vomiting
P4 = Cardiac Respiratory Arrest or Died on Table