AEC
animalemergencycentre

AEC OVERNIGHT MONITORING FORM

Patient Name: _____ Surname: _____

Age / Breed: _____

Diagnosed condition: _____ History provided: ☐ Yes ☐ No

Current Medications (please include dosages and times administered):

_____

_____

OVERNIGHT MANAGEMENT PLAN

Fluid Requirements:

Fluid Type (including additives): _____ Fluid rate: _____ml/hr

Analgesia Requirements:

Analgesia Type: _____ Next due: _____

Drug Plan:

Medication: _____ Due:_____ Provided: ☐ Yes ☐ No

Medication: _____ Due:_____ Provided: ☐ Yes ☐ No

Medication: _____ Due:_____ Provided: ☐ Yes ☐ No

Nutritional Plan (please tick):

Start Feeding: ☐ NPO overnight ☐ When recovered from GA ☐ In 4 hours ☐ In morning

Specific Instructions (e.g. bladder express):

_____

_____

_____

Instructions if treatment plan requires changes (please tick):

☐ Call me first to discuss the case Phone number to use: _____

☐ Call owners regarding the case management option but call me to update only

☐ Latest time to ring: _____ ☐ Up to midnight ☐ Anytime

☐ Phone number to use: _____

☐ Call Owners only