

 **AEC**  
animal **emergency** centre  
**OVERNIGHT CARE PACKAGE**

Referring Vet Clinic:            Referring Vet:

Patient Name:            Surname:

Species:            Age:            Breed:

Diagnosed / Suspected Condition or Problem List:

History provided:  Yes  Once Completed            Provided by: Email

Current Medications (please include dosages, routes and times administered):

**OVERNIGHT MANAGEMENT PLAN**

**Fluid Requirements:**

Fluid Type:            Fluid rate:            ml/hr

**Analgesia Requirements:**

Analgesia Type & Dose:            Route: PO Last given:            Due:

**Drug Plan:**

Medication – Dose and route:            Due:            Provided:  Yes  No

Medication – Dose and route:            Due:            Provided:  Yes  No

Medication – Dose and route:            Due:            Provided:  Yes  No

**Nutritional Plan (please tick):**

Start Feeding:  Fast overnight  When recovered from GA/Sedation  In 4 hours  In morning

Food type:

**Specific Instructions (e.g. express bladder):**

**Instructions if treatment plan requires changes (please tick):**

Call me first to discuss the case – Vet Name:            Phone number:

Call owners regarding the case management option; Call me to update only

Latest time to ring:            , or  Up to midnight  Anytime

Vet Name:            Phone number:

Call Owners only