

**The College  
of Veterinarians of Ontario**

## **Guideline**

# **Medical Records for Companion Animals**

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## Medical Records for Companion Animals

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## **Purpose**

This guideline describes the expectations of the College with respect to medical records retained for companion animals. It is based on legislation, case law, and generally accepted values of the profession. The document will be referenced by members of College committees reviewing medical records.

The guideline was developed in consultation with companion animal practitioners across Ontario. The content of this document reflects generally accepted professional standards for the preparation of companion animal medical records.

## **Scope**

This guideline applies to all practitioners involved in the care of companion animals, including dogs, cats, pocket pets, pet birds and exotic pets.

## **Relevant Legislation**

The *Veterinarians Act, R.S.O. 1990* is the profession specific legislation which governs the practice of veterinary medicine in Ontario. Regulation 1093 is the relevant regulation under that Act.

Section 7. (1) 21. of the *Act* provides Council with the authority, subject to approval of the Lieutenant Governor in Council and with prior review by the Minister, to make regulations prescribing and requiring the making and keeping of records by members of the College in respect of the practice of veterinary medicine.

Under section 7. (1) 9., Council can prescribe the records that shall be kept in respect of drug compounding, dispensing and sale.

Section 15. of the *Act* also states that, “no person shall establish or operate a veterinary facility except under and in accordance with a certificate of accreditation”.

Under Regulation 1093, R.R.O. 1990, section 17. (1) 27. and 28., professional misconduct includes failure to make or retain the records and falsifying a record regarding professional services.

Section 22. (1) (Appendix 1) contains the specific requirements on record keeping for companion animals. Section 22. (5) and (6) (Appendix 2) provide general information governing the administration and management of records.

Section 27. (1) and (2) (Appendix 3) provide the legislative requirements for record keeping on the dispensation of drugs. Section 28. (1) addresses the provisions for a controlled substance register.

Section 45. (Appendix 4) outlines the record keeping requirements with respect to vaccination programs on domestic animals for reducing exposure to rabies.

The College of Veterinarians of Ontario's *Minimum Standards for Veterinary Facilities in Ontario* Titles 1-11 state that "records are kept in the facility in accordance with the relevant provisions in the regulation." Requirements for companion animal anesthetic and surgical logs are included for hospitals, emergency clinics, specialty hospitals, spay-neuter clinics, and remote area companion animal mobiles.

## Background

The College of Veterinarians of Ontario recognizes that quality medical records can correlate strongly with quality patient care.

Appropriate records are fundamental for maintaining effective communication and optimal patient care. They should be clear, detailed, and demonstrate the rationale for all assessments and treatments performed.

Records need to be organized, logical, and self-explanatory. To accomplish this, the Data-Assessment-Plan (DAP) or Subjective-Objective-Assessment-Plan (SOAP) format can be used to provide structure and consistency. These formats also allow a ready transfer of files between facilities and practitioners, and help ensure that all relevant information is properly recorded.

The requirements for the content of a medical record are modified with respect to a rabies vaccination program as described in Appendix 4. From time to time, the College may produce position statements, policies, or guidelines that exempt practitioners from standard record keeping requirements.

## Guideline

This document consists of excerpts from Ontario Regulation 1093 and the *Minimum Standards for Veterinary Facilities in Ontario*, **in bold type**, followed by the interpretations and expectations of the College. This commentary provides guidance to members as to how they can prudently fulfill their legal and professional responsibilities.

Wherever reference is made in this document to any recorded material, including signatures, electronic versions are acceptable

**Ontario Regulation 1093 states:**

**22. (5) The records required under this section shall be,**

**(a) legibly written or typewritten;**

- Members should ensure that records can be read and properly interpreted to avoid misunderstandings that can be detrimental to patient care.
- Changes to typewritten or written records should be designated with a single line through the content or other techniques that ensure the legibility of the original entry. To avoid confusion, it is recommended that all changes be dated and initialed.

**(b) kept in a systematic manner;**

- A record may consist of many components. These can include, but are not restricted to, photographs, logs, radiographs, communications (correspondence, phone logs) laboratory data, certificates, invoices, Master Problem Lists, client information sheets, privacy forms, consent forms, protocols, templates, abbreviation lists, hospitalization/boarding sheets, client education material, fee estimates, waivers, and surgical/anesthetic monitoring sheets.
- A systematic approach to record storage can help ensure timely retrieval and that no relevant information is overlooked or misplaced. Examples include file identification by coloured folders or tabs, male/female, or identification numbers for each individual patient.
- Components should be linked, for example, by a unique identifier related to the patient.
- Records and their components should be stored logically; for example, chronologically, numerically, or alphabetically.
- It can be beneficial for the system to be properly documented and maintained by a designated individual.

**(b.1) in practices of more than one practitioner or practices that employ locums, identified after each entry with the initials or code of the veterinarian responsible for the procedure; and**

- An entry is defined as any notation regarding a procedure, client consultation, assessment, observation, progress note, and dispensation of products or pharmaceuticals.

- Entries made by non-veterinary staff in the medical record should be recorded with their initials or an employee code but do not have to be initialed by a veterinarian.

**(c) retained for a period of at least five years after the date of the last entry in the record or until two years after the member ceases to practice veterinary medicine, whichever occurs first.**

- Retiring members or those closing a facility need to ensure their records are accessible to clients, the College and others who require them. This provision can be met by transfer to another member. There is no distinction among live, dead or transferred animal medical records.

**(6) Despite subsection (5), the records required under this section may be maintained in any electronic medium that provides a visual display of recorded information if,**

**(a) the recorded information is capable of being printed promptly; and**

**(b) any changes in the recorded information are clearly indicated as changes.**

- Members should ensure that any software package utilized designates medical record revisions as a change.

**22 (1) The records required in respect of each companion animal shall contain the following information:**

**1. Patient identification, including species, age, sex.**

- Species and gender should be clearly stated and not inferred from other information presented in the record. Adequate identification includes the breed where appropriate.
- The age of the patient is best identified with the birth date so it can be readily calculated at any point in time.
- A patient is considered intact unless otherwise noted.

**2. The client's name, address and telephone numbers.**

- It is advisable to secure as much client contact information as possible. This should include residence, business, and cell phone numbers, all of which should be clearly designated in the record including the owner of each number, if applicable.

- All relevant contact information can be documented on a Client Information Sheet (Appendix 5).
  - A new Client Registration Form (Appendix 6) can assist practitioners with securing information from new clients.
- 3. If the client is likely to be absent from his or her address while the animal is confined with the member, the name, address and telephone number of a person to be contacted in case of an emergency.**
- To avoid potentially significant problems where the client might be unavailable, the record should include adequate contact information for an alternative individual and indicate whether the client has granted authority to allow him/her to act as an agent in their absence and provide consent if required. The alternative contact information should be current.
  - In the case of an emergency, all client and alternative contacts that were attempted should be documented.
- 4. Date of each time that the member sees the animal.**
- “Seeing” in this context, means any procedure, client consultation, assessment, observation, progress note, and dispensation of products or pharmaceuticals, and all entries must be dated.
- 5. A history of the animal’s health, including a record of vaccinations.**
- To allow rapid access to a patient’s history, the medical record should contain a document such as the appended Master Problem List (Appendix 7). The Master Problem List (MPL) provides an easily referenced summary of chronic and resolved medical problems, routine or annual tests (such as heartworm or other parasites), all adverse drug reactions, and allergy warnings.
- 6. The animal’s current weight.**
- The patient’s weight is recorded at each visit for determining any trends or issues of concern. The unit of measurement is clearly indicated (lbs. or kg.).

**7. Particulars of each assessment, including any laboratory investigations, performed or ordered by the member and the results of each assessment.**

- The assessment of the patient and interpretation of diagnostic tests are required components of a complete medical record. This assessment incorporates problems identified and rule-outs considered.
- A record containing only documentation of procedures performed is not complete. Records should contain assessments and interpretations of problems identified.
- Protocols and templates can make record keeping more efficient.
- A template is a diagram, chart, or checklist utilized to document information for quick recording and documentation.
- Physical examination findings are recorded in detail and can be accomplished with the use of a template (Appendix 8). Recording an examination, for example, as “PE-NAF” is not adequate unless a protocol detailing the abbreviation is included.
- Lesions may be drawn on a diagram to indicate size and location. Sample templates for eye, dental and dermatology exams are included in Appendix 9.
- A protocol documents a routine procedure that outlines in detail a particular way that the procedure or assessment is performed in the majority of cases (see Appendix 10).
- Protocols should contain references to texts, journals, and current websites. All material sourced from the internet should be printed and maintained. Any variance should be recorded with enough detail to clearly outline the nature of the variance
- All current and archived protocols should be maintained in a readily accessible central location for reference by all staff.
- Protocols should be dated with commencement date and, where appropriate, termination date.
- Acronyms and abbreviations can be used if a complete list is readily available for all staff to reference (see Appendix 11).
- Practitioners should implement a system to ensure the tracking of laboratory samples for both in-house and external laboratories. The system records where and when the sample was sent, when the results were received, and the implications were discussed with the client (see Appendices 12 (external) and 13 (internal) for laboratory tracking logs).

- 8. A note of any professional advice given regarding the animal and an indication of when and to whom such advice was given if other than to the client.**
- Descriptions of advice given must be clearly documented, including diagnostic, treatment, and surgical options and implications.
  - Personal and telephone communication with clients or agents of clients involved in patient care should be included in the record and documented by date. All parties involved in the communication should be identified. If a message is left on a voicemail, this information should be documented, including the approximate time and date.
  - All recommendations and estimates, including those for surgical or medical treatment, diagnostic testing, or referral for specialized care should be documented in a Treatment Plan.
  - If a recommendation is declined, it should be noted in the record, along with the reasons given by the client, if any, and details of the remaining discussion (e.g. risks, alternatives).
  - If arrangements have been made for on-going treatment, and are then cancelled by the client or veterinarian, these should be documented in the medical record along with the reasons for the cancellation.
  - A copy of all home instructions and discharge summary sheets should be recorded or included in the medical record (See Appendix 14 for Discharge Summary Sheet).
- 9. All medical or surgical treatments and procedures used, dispensed, prescribed or performed by or at the direction of the member, including the name, strength, dose and quantity of any drugs.**
- Drug information contained in the record should include the name of the drug, the strength, dose, route of administration and quantity. A second copy of the prescription label included in the record may be an efficient way of recording this information. If a prescription can be repeated, this should be noted. If there is a significant warning or side effect associated with the drug, this should be conveyed to the client and recorded.
  - If a compounded medication is dispensed, the name of the Compounding Pharmacy and the Prescription number should be recorded.

- A description of a complete record for drug dispensation is found in Ontario Regulation 1093, Section 27.
- It is recommended that written surgical protocol notes contain details of the approach used, findings, type of repair, suture material used, any material implanted, and the closure technique. In the case of surgery, e.g. spay, this could be done by recording something as simple as “spay, immature” or “spay, mature in heat”; however, the protocol used by the member should be described and maintained in a readily accessible central location for reference (see Appendix 15). Any variance should be recorded with enough detail to clearly outline the nature of the variance.
- It is recommended that anesthetic protocol notes contain the name and dose of induction agent(s), the name, dose or concentration and delivery method of the maintenance agent and any changes made to that dose or concentration. If an endotracheal tube is used, then size, cuffed or non-cuffed, should be recorded.
- The anesthetic monitoring protocol should contain a time-based record of the patient’s heart rate, respiratory rate, CRT and a notation of the depth of the anesthetic as well as a record of when the anesthetic started and finished.
- See Appendix 21 for surgery/anesthetic monitoring sheets to effectively record all relevant information.
- Many medical and surgical treatments include the administration of intravenous fluids, a description of which should be included in the medical record (a sample fluids monitoring sheet is included in Appendix 16). The description should include the type of fluid, rate of administration, changes to the rate of administration, when the change occurred, and any drugs added to the fluids.
- An example 24-hour treatment/monitoring sheet for hospitalized patients is included in Appendix 17.

**9.1 One of the following with respect to each surgical treatment:**

- (i) The written consent to the surgical treatment signed by or on behalf of the owner of the animal.**
- (ii) A note that the owner of the animal or a person on the owner’s behalf consented orally to surgical treatment, and the reason why the consent was not in writing.**
- (iii) A note that neither the owner of the animal nor anyone on the owner’s behalf was available to consent to the surgical treatment, and the reason why, in the member’s opinion, it was medically advisable to conduct the surgical treatment.**

- Consent forms signed by clients should be maintained in the record, in paper or electronic format (see Appendix 18 for sample consent form).
- Consents obtained via telephone should be documented in the medical record, and if possible witnessed and initialed by a third party.
- All companion animal practices should obtain signed consent forms for all elective surgical procedures. In the case of emergencies, a verbal authorization is adequate if the medical record contains a notation regarding the name of the person who provided consent.

**10. A copy of all reports prepared by the member in respect of the animal.**

- Reports such as health certificates and letters of referral to specialists should be included in the medical record.

**11. A final assessment of the animal.**

- The record should include the ultimate diagnosis or explanation for the presenting signs to the extent it is available and a plan documented.

**12. The fees and charges, showing separately those for drugs and those for advice or other services.**

- An invoice is a component of the medical record.

### ***Radiographs***

Under the *Minimum Standards for Veterinary Facilities in Ontario*, requirements for designated facilities include:

**The facility (hospitals and emergency clinics) contains,**

**radiographs all of which are permanently identified with,**

- 1. the name of the veterinarian or the designation of a facility or both,**
- 2. identification of the animal,**
- 3. the date of the radiograph,**
- 4. an indication of the left or right side of the animal,**
- 5. an indication of time for sequential radiographic studies.**

- This information should be exposed on the film; however a label or indelible pen may be used to improve legibility.

**a radiographic log in which is entered,**

- 1. the date each radiograph is taken,**
  - 2. identification of the animal and the client,**
  - 3. the area of the body exposed to the radiograph.**
- A radiographic log should include the technique used to take the picture. A sample radiology log is included in Appendix 19.

### ***Anesthetic and Surgical Logs***

The *Minimum Standards for Veterinary Facilities in Ontario* provides the following provisions for surgical and anesthetic logs:

**The facility (hospitals, emergency clinics, and spay-neuter clinics) contains an anesthetic log, either alone or in combination with the surgical log, in which is entered in respect of each induction of general anesthesia in the facility,**

- 1. the date of induction,**
- 2. the name of the client,**
- 3. the breed, age, sex, weight and identity of the anesthetized animal,**
- 4. the pre-anesthetic condition of the animal, e.g. whether the animal was healthy; indicated a mild disease; indicated an existing disease with mild systemic reaction; or indicated acute or severe systemic disease**
- 5. the name, dose, and route of administration of any pre-anesthetic agents,**
- 6. the name, dose, and route of administration of anesthetic agents,**
- 7. the nature of the procedures performed under the anesthetic,**
- 8. 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.**

**The facility (hospital, emergency clinic, spay-neuter clinic) contains a surgical log, either alone or in combination with the anesthetic log, in which is entered in respect of each major surgical procedure performed in the facility,**

1. the date of each procedure,
2. the name of the client,
3. the breed, age, sex, weight and identity of the animal upon which the procedure is performed,
4. the name of the surgeon,
5. the nature of each procedure,
6. 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,
7. 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
8. the length of time taken to perform the procedure.
  - An example of a surgery/anesthetic log is contained in Appendix 20.
  - Chronological storage of individual surgery and anesthetic monitoring sheets (see Appendix 21 for sample sheets) can satisfy the requirements for a surgery/anesthetic log.
  - An entry in the log is not required for procedures where the patient is tranquilized or sedated.

### ***Drug Dispensation***

Section 27. of Regulation 1093 contains the following specific provisions for the dispensation of drugs, including:

**27 (1) A member who dispenses a drug shall make a written record showing,**



- (a) the name and address of the owner of the animal or group of animals for which the drug is prescribed;
- (b) the name, strength and quantity of prescribed drug;
- (c) the directions for use if they are different than the directions for use on the manufacturer's label or if the manufacturer's label does not specify the directions for use;
- (d) the date on which the drug is dispensed; and
- (e) the price charged.

**(2) The member shall retain the written record required under subsection (1) for a period of at least five years or until he or she ceases to practice veterinary medicine, whichever occurs first.**

### ***Controlled Substances***

Section 28. (1) of Regulation 1093 contains provisions for practitioners dispensing a controlled substance and the maintenance of a controlled substance register. The requirements include:

**28 (1) A member who dispenses a controlled substance shall keep a controlled substance register in which is entered,**

- (a) the date of the dispensing;**
- (b) the name and address of the owner of the animal or animals for which the drug was dispensed;**
  - “dispense” means administer, sell, distribute or give away (O. Reg. 1093 23. (1))
  - It is acceptable to utilize a unique identifier code that can be cross referenced (for example, to the client information sheet) to provide this information.
  - Controlled substances include narcotics, barbiturates and anabolic steroids among others.
- (c) the name, strength, and quantity of the drug dispensed; and**
- (d) the quantity of the drug remaining after dispensing.**
  - All entries in the controlled substance register should be initialed by the prescribing veterinarian to ensure accountability.
  - The surgery/anesthetic log cannot be used as a controlled substance register.
  - A controlled substance is identified with a  or .
  - A sample controlled substance register is included in Appendix 22.
  - An entry must be made in the register for any of the following situations:
    - A controlled substance that has been prescribed for an individual patient is dispensed for home administration.
    - A controlled substance that has been prescribed for an individual patient is administered to the patient while it is in the hospital.

- A controlled substance has been used in the compounding of other preparations (e.g. butorphanol – acepromazine – glycopyrrolate).
  - In this case an entry must be made in the register documenting the transfer of the controlled substance (butorphanol) to the preparation (BAG)
  - A second register for the preparation (BAG) must be maintained in which it is documented each time the preparation is administered to a particular patient.

Under the *Minimum Standards for Veterinary Facilities in Ontario*, the following sections govern record keeping requirements for ketamine and targeted drugs in hospitals, offices, mobile offices, mobiles, emergency clinics, and spay-neuter clinics:

**A member who dispenses Ketamine shall keep a Ketamine register in which is entered,**

- 1. the date of dispensing,**
- 2. the name and address of the owner of the animal or animals for which the drug was dispensed,**
  - It is acceptable to utilize a unique identifier code that can be cross referenced (for example, to the client information sheet) to provide this information.
- 3. the name, strength, and quantity of the drug dispensed, and**
- 4. the quantity of the drug remaining after dispensing.**
  - All entries in the ketamine register should be initialed by the prescribing veterinarian to ensure accountability.
  - The surgery/anesthetic log cannot be used as a ketamine substance register.
  - The sample controlled substances register included in Appendix 22 can be used as a ketamine register.
  - An entry should be made in the ketamine register for any of the following situations:
    - Ketamine prescribed for an individual patient is administered to the patient while it is in the hospital.
    - Ketamine has been used in the compounding of other preparations (e.g. ketamine - acepromazine )

- In this case an entry should be made in the ketamine register documenting the transfer of ketamine to the preparation.
- A second register for the preparation (ketamine-acepromazine) should be maintained in which it is documented each time the preparation is administered to a particular patient.

**A member who dispenses a targeted drug shall keep a targeted drug register in which is entered,**

- 1. the date of dispensing,**
- 2. the name and address of the owner of the animal or animals for which the drug was dispensed,**
  - It is acceptable to utilize a unique identifier code that can be cross referenced (for example, to the client information sheet) to provide this information.
- 3. the name, strength, and quantity of the drug dispensed, and**
- 4. the quantity of the drug remaining after dispensing**
  - All entries in the targeted drug register should be initialed by the prescribing veterinarian to ensure accountability.
  - The surgery/anesthetic log cannot be used as a targeted drug register.
  - Targeted drugs include all those with the symbol “☒” appearing beside the drug name and includes diazepam.
  - The sample controlled substance register included in Appendix 22 can be used as a targeted drug register.
  - An entry should be made in the targeted drug register for any of the following situations:
    - A targeted drug that has been prescribed for an individual patient is dispensed for home administration.
    - A targeted drug that has been prescribed for an individual patient is administered to the patient while it is in the hospital.
    - A targeted drug has been used in the compounding of other preparations (e.g. ketamine - diazepam)
      - In this case an entry should be made in the ketamine register documenting the transfer of ketamine to the preparation (see ketamine register above) and an entry should be made in the targeted drug register documenting the transfer of diazepam to the preparation.

- A separate register for the preparation (ketamine-diazepam) should be maintained in which it is documented each time the prescribed preparation is administered to a particular patient.

## APPENDIX 1 – O REG SECTION 22 (1)

Ontario Regulation 1093 section 22 (1) defines the medical records requirements for companion animals. The specific provisions are:

**22. (1) The records required in respect of each companion animal shall contain the following information:**

- 1. Patient identification, including species, age and sex.**
- 2. The client's name, address and telephone numbers**
- 3. If the client is likely to be absent from his or her address while the animal is confined with the member, the name, address and telephone number of a person to be contacted in case of an emergency.**
- 4. Date of each time that the member sees the animal.**
- 5. A history of the animal's health, including a record of vaccinations.**
- 6. The animal's current weight.**
- 7. Particulars of each assessment, including any laboratory investigations, performed or ordered by the member and the results of each assessment.**
- 8. A note of any professional advice given regarding the animal and an indication of when and to whom such advice was given if other than to the client.**
- 9. All medical or surgical treatments and procedures used, dispensed, prescribed or performed by or at the direction of the member, including the name, strength, dose, and quantity of any drugs.**
  - 9.1 One of the following with respect to each surgical treatment:**
    - i) The written consent to the surgical treatment signed by or on behalf of the owner of the animal.**
    - ii) A note that the owner of the animal or a person on the owner's behalf consented orally to the surgical treatment, and the reason why the consent was not in writing.**



## APPENDIX 2 – O REG SECTION 22 (5) AND (6)

**22 (5) The records required under this section shall be,**

- (a) legibly written or typewritten;**
- (b) kept in a systematic manner;**
- (b.1) in practices of more than one practitioner or practices that employ locums, identified after each entry with the initials or code of the veterinarian responsible for the procedure; and**
- (c) retained for a period of at least five years after the date of the last entry in the record or until two years after the member ceases to practice veterinary medicine, whichever comes first.**

**22 (6) Despite subsection (5), the records required under this section may be maintained in any electronic medium that provides a visual display of recorded information if,**

- (a) the recorded information is capable of being printed promptly;  
and**
- (b) any changes in the recorded information are clearly indicated as changes. R.R.O. 1990, Reg. 1093, s. 22 (6)**

## APPENDIX 3 – O REG SECTION 27 (1) AND (2)

**27 (1) A member who dispenses a drug shall make a written record showing,**

- (a) the name and address of the owner of the animal or group of animals for which the drug is prescribed;**
- (b) the name, strength and quantity of prescribed drug;**
- (c) the directions for use if they are different than the directions for use on the manufacturer's label or if the manufacturer's label does not specify the directions for use;**
- (d) the date on which the drug is dispensed; and**
- (e) the price charged. R.R.O. 1990, Reg. 1093, s. 27 (1)**

**(2) The member shall retain the written record required under subsection (1) for a period of at least five years or until he or she ceases to practice veterinary medicine, whichever occurs first. R.R.O. 1990, Reg. 1093, s. 27 (2)**

## APPENDIX 4 – O REG SECTION 45 (1), (3) AND (4)

**45 (1) If a member or group of members sponsors a program to vaccinate domestic animals in order to reduce human exposure to rabies, the member may advertise the location, date and time of the program, the names of participating members and the cost of the vaccination if,**

**(a) all members practising in the area are invited to participate in the program at least two weeks before the vaccinations are to be carried out;**

**(b) the co-operation of the medical officer or officers of health for the area is requested; and**

**c) the Registrar is given written notification of the program at least two weeks before the vaccinations are to be carried out and the notice confirms that there has been compliance with clauses (a) and (b). R.R.O. 1990, Reg. 1093, s. 45 (1)**

**(3) The records in section 22 are not required in respect of a vaccination carried out in a program under subsection (1), but a member shall record,**

**(a) a reasonable identification of the vaccinated animal;**

**(b) the owner's name, address, and telephone numbers;**

**(c) the date and fact of vaccination; and**

**(d) the type of vaccine, including the lot and serial number of the vaccine administered. R.R.O. 1990, Reg. 1093, s. 45 (3)**

**(4) The information recorded under subsection (3) shall be maintained in a systematic manner by the members organizing the program. R.R.O. 1990, Reg. 1093, s. 45 (4)**

# EXAMPLES OF MEDICAL RECORDS FORMS

THE FOLLOWING FORMS ARE PROVIDED FOR YOUR ASSISTANCE. THEIR USE IS NOT MANDATORY.

## APPENDIX 5 – CLIENT INFORMATION SHEET

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

### Alternate Contact

<b>Name:</b>	
<b>Address:</b>	
<b>Residence Phone:</b>	
<b>Business/ Workplace Phone:</b>	
<b>Cell Phone:</b>	
<b>Consent to act as Client's Agent:</b>	<b>Y / N</b>
<b>Client's Signature:</b>	

# APPENDIX 6 – CLIENT REGISTRATION FORM

## Client

Name:	
Address:	
Residence Phone:	Business/ Workplace Phone:

## Patient Information

Name:		
Dog:	Cat:	Other:
Breed:	Colour:	
Birth Date:		
Tattoo:	Microchip:	
Markings:		
Previous Veterinarian:		
Confirmation to request files: Y/N		
Last treatments:		
Any known drug allergies:		
Prior illness/surgery:		
Medications:		
Diet restrictions/supplements:		
Reason for initial visit:		

\_\_\_\_\_, DVM

Date: \_\_\_\_\_

## APPENDIX 7 - MASTER PROBLEM LIST

<b>Animal ID:</b>						<b>Client:</b>						
						<b>File #:</b>						
<b>Species:</b>						<b>Breed:</b>						
<b>Birth date:</b>						<b>Male or Female</b>						
<b>Neutered:</b> <b>Yes</b> <b>No</b>												
<b>Warnings (e.g. drug allergies, behaviour problems etc):</b>												
<b>Ongoing Medications:</b>												
<b>Procedures:</b>		<b>Date</b>										
<b>Vaccinations</b>												
<b>FeLV/FIV (+/-)</b>												
<b>HWT</b>												
<b>Intestinal Parasites</b>												
<b>Weight (kg)</b>												
<b>Date</b>	<b>Assessment</b>					<b>Treatment</b>			<b>Diagnostics</b>			

# APPENDIX 8 - EXAMINATION TEMPLATE

Client: \_\_\_\_\_ Animal ID: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

## SPECIAL NOTES:

## Presenting Complaint:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Frequency & Duration: \_\_\_\_\_  
 Previous treatment for problem: \_\_\_\_\_  
 Response to treatment: \_\_\_\_\_

## SUBJECTIVE FINDINGS:

<b>Appetite:</b> Nrm ___ Abn ___ N/A ___	<b>Drinking:</b> Nrm ___ Abn ___ N/A ___	<b>Coughing:</b> Yes ___ No ___ Occ ___	<b>Sneezing:</b> Yes ___ No ___ Occ ___
<b>Attitude:</b> Nrm ___ Abn ___ N/A ___	<b>Vomiting:</b> Yes ___ No ___ Occ ___	<b>Bowels:</b> Nrm ___ Abn ___ N/A ___	<b>Urination:</b> Nrm ___ Abn ___ N/A ___

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## OBJECTIVE FINDINGS:

TEMP _____	HR _____	RR _____	MM _____	CRT _____	Wt _____
1. <b>Abdomen/Palpation:</b> Nrm ___ Abn ___ N/E ___	4. <b>Heart:</b> Nrm ___ Abn ___ N/E ___	7. <b>Musculoskeletal:</b> Nrm ___ Abn ___ N/E ___	10. <b>Respiratory:</b> Nrm ___ Abn ___ N/E ___		
2. <b>Ears:</b> L / R Nrm ___ Abn ___ N/E ___	5. <b>Integument:</b> Nrm ___ Abn ___ N/E ___	8. <b>Neurological:</b> Nrm ___ Abn ___ N/E ___	11. <b>Urogenital:</b> Nrm ___ Abn ___ N/E ___		
3. <b>Eyes:</b> L / R Nrm ___ Abn ___ N/E ___	6. <b>Lymphatic:</b> Nrm ___ Abn ___ N/E ___	9. <b>Oral Cavity:</b> Nrm ___ Abn ___ N/E ___	12. <b>Body condition Score:</b>		

**Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HISTORY (animal health and record of vaccinations):**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

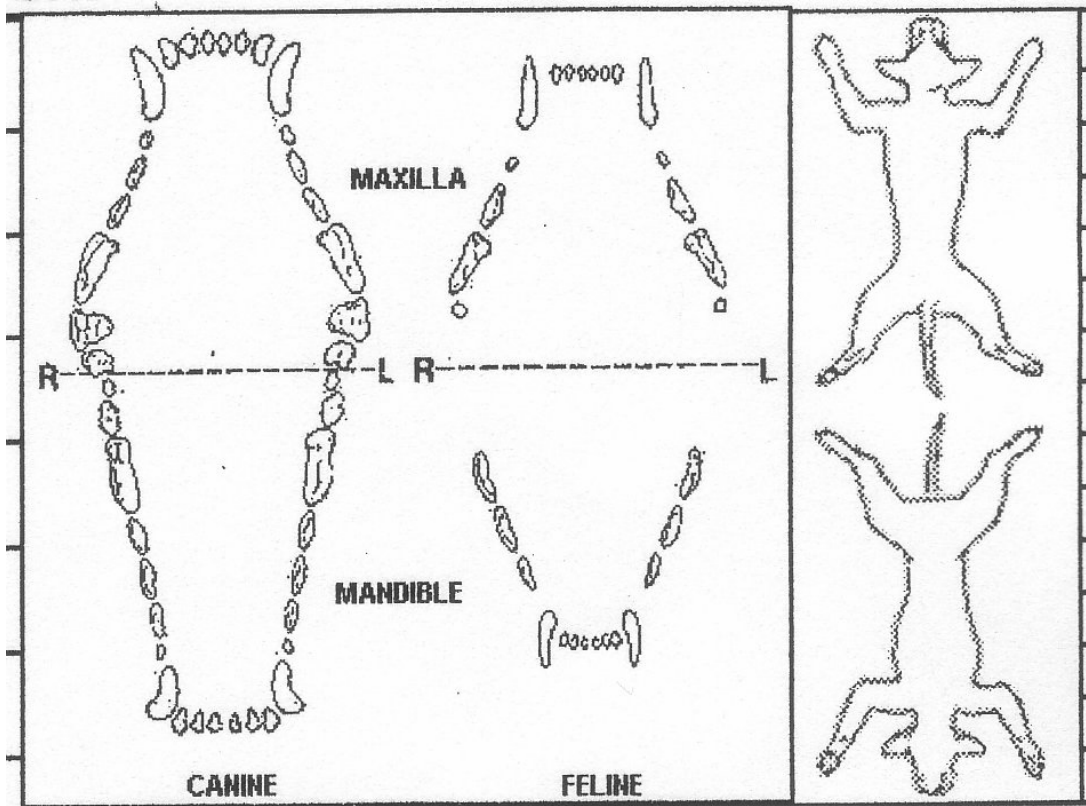
**ASSESSMENT/ DX:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLANS/TREATMENT:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RECOMMENDATIONS/INSTRUCTION TO OWNER:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DVM \_\_\_\_\_ Date \_\_\_\_\_

# APPENDIX 9 – EYE / DENTAL / DERMATOLOGICAL TEMPLATE



DATE: \_\_\_\_\_

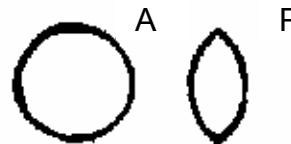
CLIENT: \_\_\_\_\_

ANIMAL ID: \_\_\_\_\_

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

OD

OS



# APPENDIX 10 - 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 pinnae 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 ophthalmoscope 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.

## APPENDIX 11 – 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





## APPENDIX 14 - DISCHARGE SUMMARY SHEET

<b>Animal ID:</b>	<b>Client:</b>
<b>Diagnosis:</b>	
<b>Treatment / Tests:</b>	
<b>Medications:</b>	
<b>Exercise:</b>	
<b>Dietary Directions:</b>	
<b>Recheck Date:</b>	
<b>Doctor:</b>	
<b>Additional Instructions:</b>	

\_\_\_\_\_, DVM

Date \_\_\_\_\_

# APPENDIX 15 – SURGICAL PROTOCOLS

## Canine Castration

Utilized by: Dr. \_\_\_\_\_

Dates Utilized: i.e. 2003-present

Reference:

Journal / Text: \_\_\_\_\_

Title: \_\_\_\_\_

Pages: \_\_\_\_\_

### Method:

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 [insert name].

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 [insert name] in a continuous subcuticular suture pattern.

Any variations to the above format will be recorded in the patient's medical records.

## Ovariohysterectomy – routine immature cat

Utilized by: Dr. \_\_\_\_\_

Dates Utilized: i.e. 2003-present

### Reference:

Journal / Text: \_\_\_\_\_

Title: \_\_\_\_\_

Pages: \_\_\_\_\_

### Method:

The cat is anesthetized and the bladder manually expressed of any urine. The ventral abdomen is clipped and surgically prepped 3 times with [*insert name*] scrubs, alcohol and a final [*insert name*] 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 [*insert name*] is placed. The procedure is repeated with the left ovary. The uterine body is exteriorized with the broad ligament broken. A [*insert name*] 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 [*insert name*] in a simple interrupted pattern. The subcutaneous tissues are closed with [*insert name*] in a similar continuous pattern. Skin closure is by means of a simple interrupted pattern using [*insert name*].

## Ovariohysterectomy – routine mature cat

Utilized by: Dr. \_\_\_\_\_

Dates Utilized: i.e. 2003-present

### Reference:

Journal / Text: \_\_\_\_\_

Title: \_\_\_\_\_

Pages: \_\_\_\_\_

### 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.

## Ovariohysterectomy – routine immature dog

Utilized by: Dr. \_\_\_\_\_

Dates Utilized: i.e. 2003-present

### Reference:

Journal / Text: \_\_\_\_\_

Title: \_\_\_\_\_

Pages: \_\_\_\_\_

### Method:

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 [insert name]. 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 [insert name]. The linea alba is closed with a simple interrupted suture pattern using [insert name] for dogs weighing less than 5 kg and [insert name] for dogs greater than 5 kg in weight. The subcutaneous tissues are closed with a simple continuous pattern using [insert name] for dogs weighing less than 5 kg and [insert name] for dogs weighing more than 5 kg. The skin is closed with an interrupted pattern using [insert name] sutures.



# APPENDIX 17 – 24 HOUR TREATMENT / MONITORING SHEET

<b>Animal ID:</b>												<b>Client:</b>												
<b>Date:</b>																								
<b>Weight:</b>																								
<b>Problem List:</b>																								
1.																								
2.																								
3.																								
4.																								
Am	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6
<b>T</b>																								
<b>P</b>																								
<b>R</b>																								
<b>MM Colour</b>																								
<b>CRT (sec)</b>																								
<b>Attitude</b>																								
<b>Fluids mls/hr</b>																								
<b>Fluids in</b>																								
<b>Urine out</b>																								
<b>BM</b>																								
<b>Vomit</b>																								
<b>Food</b>																								
<b>Water</b>																								
<b>Medications</b>																								
<b>Medications</b>																								
<b>Medications</b>																								
<b>Diagnosics</b>																								
<b>Diagnosics</b>																								
<b>Diagnosics</b>																								

# APPENDIX 18 – INFORMED OWNER CONSENT

Owner /  Owner's Agent: \_\_\_\_\_

Contact Telephone Number(s): \_\_\_\_\_ or \_\_\_\_\_

Alternate Contact Person: \_\_\_\_\_ Alternate's Phone #: \_\_\_\_\_

Animal/Herd/Flock ID: \_\_\_\_\_ Animal Name: \_\_\_\_\_

Species: \_\_\_\_\_ Sex: M F

Breed: \_\_\_\_\_ Colour: \_\_\_\_\_

I, the undersigned, being 18 years of age or older, am the owner or agent of the owner of the animal(s) described above and am authorized to make decisions regarding its case.

I hereby acknowledge that my veterinarian, Dr. \_\_\_\_\_, or his/her representative, \_\_\_\_\_ has advised me of and explained the following (check off as each one is discussed):

- The presenting complaint(s) / tentative or final diagnosis of my animal(s).
- The general nature of the following proposed treatment/procedure(s):  
\_\_\_\_\_
- The expected benefits of the above.
- The reasonable risks or dangers and side effects of the above.
- Reasonable alternative courses of action available, and risks/benefits of each.
- Consequences if the treatment/procedure is not performed.
- That auxiliaries or other veterinarians may be providing some of the treatment and care of the animal(s).
- Cost of the treatment/procedure.

Further, in the event that I am unavailable, I give permission to discuss financial and medical aspects of this case with:

(Name: \_\_\_\_\_ Number(s): \_\_\_\_\_)

I understand that there can be no guarantee as to the animal's condition or reaction to or the outcome of any procedure/treatment undertaken. My questions have been answered, I have read or had explained to me and fully understand the information on this form, and declare that I understand and voluntarily consent to the recommended treatment/procedures.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Owner/  Owner's Agent

\_\_\_\_\_  
 Signature of Veterinarian/  Representative

Date: \_\_\_\_\_



## APPENDIX 20 - SURGERY / ANESTHETIC LOG

DATE	CLIENT/ ANIMAL ID	BREED	AGE/ GENDER/ WEIGHT	PROCEDURE	CONDITION		ANESTHETIC REGIMES Pre/Induction/Main			Other	TIME (min.)		DR's INIT.
					Pre- op C1-4	Post- op P1-4	Pre-Anesthetic Name/Dose/Route	Induction Anesthetic Name/Dose/Route	Maintenance Anes. 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

## APPENDIX 21 - SURGERY / ANESTHETIC MONITORING SHEETS

<b>Date:</b>												
<b>Client:</b>						<b>Animal ID:</b>						
<b>Species:</b>			<b>Breed:</b>			<b>Age:</b>			<b>Weight:</b>			
<b>Procedure:</b>												
<b>Surgeon:</b>						<b>Assistant:</b>						
<b>Pre-Anesthetic Agent:</b>				<b>Dose:</b>				<b>Route:</b>				
<b>Induction Agent:</b>				<b>Dose:</b>				<b>Route:</b>				
<b>Pre-Op Status:</b>						<b>Post-Op Status:</b>						
<b>E.T.T. Size:</b>			<b>Cuffed ف</b>			<b>Non Cuffed ف</b>						
<b>Minutes</b>												
	<b>0</b>	<b>10</b>	<b>20</b>	<b>30</b>	<b>40</b>	<b>50</b>	<b>60</b>	<b>70</b>	<b>80</b>	<b>90</b>	<b>100</b>	<b>110</b>
<b>L/min Oxygen</b>												
<b>[insert name] %</b>												
<b>[insert name] %</b>												
<b>R.P.M</b>												
<b>Heart Rate B.P.M.</b>												
<b>Comments:</b>												
<b>Start Incision:</b>				<b>Begin Close:</b>				<b>Anesthetic Off:</b>				
<b>Patient Status:</b>												

**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

\_\_\_\_\_, DVM Date \_\_\_\_\_

