

まじこ

VETERINARY MEDICAL TEACHING HOSPITAL

University of Wisconsin – School of Veterinary Medicine
2015 Linden Drive, Madison, WI 53706-1102
Phone: 608-263-7600, 800-386-8684; FAX: 608-265-8276

たまご

MEDICAL REC #:	123074	EXAMINATION DATE:	03/11/08	DISCHARGED:	3/11/08
VISIT ID:	0831561	OWNER:	Kotoyo Hoshina		
PATIENT:	Mango	ADDRESS:	5002 Sheboygan Ave		
SPECIES:	Lapine		Apt 120		
BREED:	Other Lapine (Rabbit)		Madison, WI 53705		
COLOR:	Red/White	HOME PHONE:	(608) 334-5123		
SEX:	Male	WORK PHONE:	-		
DOB:	09/12/06				
REFERRING DVM:		PHONE:	-		
		FAX:	-		
		SERVICE:	Special Species		
CLINICIAN(S):	Joanne Paul-Murphy, DVM	STUDENT(S):	Christy Rettenmund		

Current diagnostic impressions:

DIAGNOSIS	COMMENTS
Intact male	Neuter performed 3/11/08

Instructions for care after discharge:

- FEEDING: Usual diet Special
EXERCISE: No restrictions Special

Instructions:
Instructions: Please do not allow Mango to jump off any furniture or breed with the females for the next 3 days

MEDICATION	SIZE/QUANTITY	INSTRUCTIONS
Meloxicam	0.6 mg	This is a non-steroidal anti-inflammatory for treatment of pain. Please give 0.6 mg (0.4 mls) once daily orally for the next 4 days. Mango has already received a dose of Meloxicam today so this medication should be started tomorrow.

Tests performed during this visit:

TEST	RESULT
E.cuniculi titer	

Additional instructions and comments:

Mango is a 1.5 year old male rabbit. He presented to the VMTH to be neutered. Physical exam revealed the presence of two testicles in the scrotal sacs. All other physical exam findings were within normal limits.

Mango was placed under general anesthesia today to allow a neuter to be performed. An incision was made in each scrotal sac and the testicles were removed. The incisions were left open to allow for drainage. The incisions should be examined daily for excessive discharge or swelling. The incisions can be treated by placing a cold pack between the hind legs over the scrotum several times over the next 24 hours. He received a dose of Meloxicam today but should continue to receive one dose of the

VETERINARY MEDICAL TEACHING HOSPITAL

University of Wisconsin – School of Veterinary Medicine
2015 Linden Drive, Madison, WI 53706-1102
Phone: 608-263-7600, 800-386-8684; FAX: 608-265-8276

Meloxicam in the morning for the next 4 days starting tomorrow. Please don't hesitate to contact the VMTH if the incisions become very swollen or there is a lot of discharge from the incisions.

The E. cuniculi titer should be available in 1 week. Please call the VMTH for results if you do not receive a call from us in 1 week.

Thank you for bringing Mango in to the VMTH today. He is a very sweet rabbit and was a pleasure to work with!

Follow-up examination and communication

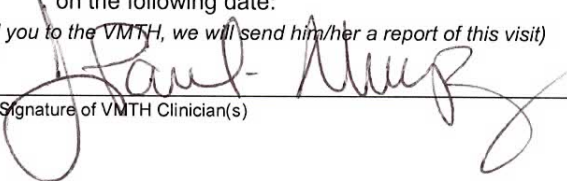
Follow-up Not required

- At VMTH:** Please set up appointment for: routine care on the following date: as needed
 Please provide us with a progress report by telephone, fax, or letter on or about this date:
 We will call you with the following information:

Follow-up at regular DVM: Not Required

Please set up an appointment for: _____ on the following date: _____
(If you have a local veterinarian who referred you to the VMTH, we will send him/her a report of this visit)

Signature of Owner/Agent



Signature of VMTH Clinician(s)

Referring Veterinarian Report:

ESTIMATE ONLY

DATE 2/11/08

123074
 MANGO
 RED/WHITE
 LAP OTHER LAPINE M 09/15/07
 HOSHINA, KOTOYO
 5002 SHEBOYGAN AVE
 MADISON, WI 53706
 PHONE 608-334-5123
NOT A BILL

HOSPITAL ESTIMATE*

UNIVERSITY OF WISCONSIN - MADISON
 SCHOOL OF VETERINARY MEDICINE
 VETERINARY MEDICAL TEACHING HOSPITAL
 2015 Linden Drive West
 Madison, WI 53706
 (608) 263-7600

(OWNER IDENTIFICATION AND ANIMAL DESCRIPTION)

DOCTOR: Roux-Murphy

PROBLEMS:

EXAMINATION	ESTIMATED COSTS	
	From	To
BY APPOINTMENT _____	\$ _____	\$ _____
EMERGENCY _____	\$ _____	\$ _____
_____	\$ _____	\$ _____
CONSULTATION _____	\$ _____	\$ _____
LABORATORY: Hematology & Chemistry _____	\$ _____	\$ _____
Microbiology _____	\$ _____	\$ <u>40</u>
Histopathology _____	\$ _____	\$ _____
Parasitology _____	\$ _____	\$ _____
RADIOLOGY _____	\$ _____	\$ _____
_____	\$ _____	\$ _____
HOSPITALIZATION DAYS () _____	\$ _____	\$ _____
IN-HOSPITAL MEDICATIONS _____	\$ _____	\$ _____
_____	\$ _____	\$ _____
MEDICATIONS DISPENSED _____	\$ _____	\$ <u>40 -</u>
_____	\$ _____	\$ _____
SURGERY _____	\$ _____	\$ <u>150 -</u>
SURGICAL IMPLANTS _____	\$ _____	\$ _____
ANESTHESIA _____	\$ _____	\$ _____
SPECIAL CARE/ICU _____	\$ _____	\$ _____
OTHER _____	\$ _____	\$ _____
TOTAL ESTIMATE	\$ _____	\$ <u>230 -</u>

*This initial estimate is based upon entering examination of your animal by the clinician and may change as diagnostic and therapeutic procedures deem necessary. Following the initial examination by a clinician, a deposit of 50 percent of the Hospital Estimate must be made before further diagnostic and/or therapeutic procedures are initiated. Upon discharge, the charges are to be paid in full. Please contact the doctor or the reception desk if you have any questions (263-7600). **UNPOSTED FEES:** In some instances, charges for services rendered in the hospital may still be in the processing stage when you pick up your animal. The client agrees to pay for these services when a bill is received.

WHITE - MEDICAL RECORD YELLOW - CLIENT PINK - BILLING

CLIENT ACKNOWLEDGEMENT Kotoyo Hoshina DATE 03/11/2008

UNIVERSITY OF WISCONSIN - MADISON
SCHOOL OF VETERINARY MEDICINE
VETERINARY MEDICINE TEACHING HOSPITAL

123074
MANGO
LAP OTHER LAP
MOSHINA, KOTOYO
5000 SHEDDOYGA AV
MADISON, WI 53706
608-334-3113



I am the owner or agent of the owner of the above described () flock, () herd, (X) animal and have the authority to execute this document.

I hereby authorize agents of the University of Wisconsin - Madison School of Veterinary Medicine to perform **the following procedure(s) or treatment(s)** upon my animal(s): _____

gastroenteritis, colitis

The nature and purpose of these procedures and treatments, and available alternative treatments have been explained to me. I understand **the major risks** associated with the procedures and treatments I am authorizing include _____

I further acknowledge that no guarantee has been made as to results that may be obtained. I understand that complications may arise which cannot be predicted and that **I will be held financially responsible for any veterinary medical care necessitated by complications.**

I consent to the administration of sedatives and anesthetic agents as deemed appropriate by the veterinarian in charge.

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 or treatments if reasonable efforts to contact me for further consent are unsuccessful.

I understand that students at the School of Veterinary Medicine will be present and may participate in performing the procedures and treatments I have authorized.

Signed *Kotoyo Hoshino*
Owner or authorized agent of owner

Date *03/11/2008*

If someone other than the owner is signing this authorization, provide:

Address _____

--CLIENT INVOICE--

University of Wisconsin - Madison
Veterinary Medical Teaching Hospital
2015 Linden Drive
Madison, WI 53706
608-263-7600 or 1-800-DVM-VMTH
<http://vmthpub.vetmed.wisc.edu/>

KOTOYO HOSHINA
5002 SHEBOYGAN AVE
APT 120
MADISON, WI 53705

Date: 03/11/08

Account: 137820

Patient		Amount
	Previous Balance Due	
	OR Deposit Credit (-)	0.00
Mango		
	Charges: ANESTHESIA	66.30
	CLINICAL PATHOLOGY	33.20
	PHARMACY	37.00
	SA-SOFT TISSUE SURGERY	0.00
	SA-SPECIAL SPECIES	44.50
	Total Due	181.00
	03/11/08 PAYMENT BY VISA	150.00-
	Payment Due	31.00
Clinician: Joanne Paul-Murphy, DVM		

This invoice reflects currently processed charges. Additional charges may be forwarded to the cashier and will be billed separately.