



Casper Animal Medical Center

4700 South Valley Road

Casper, WY 82604

(307) 237-8387

camc@casperpets.com

Consent for Surgical Treatment

Date: ____/____/20____

Animal Name: _____ Client Name: _____

(initial)_____ I verify that I am the owner, or authorized agent for the owner, of the animal described above. My signature at the end of this form verifies that I am over eighteen years of age.

My pet is scheduled for the following procedure: _____

(initial)_____ I verify that I have followed all standard pre-surgical instructions, and that my pet has not eaten food or treats since 9:00pm the night prior to surgery, UNLESS my pet has a chronic condition that prohibits them from fasting (i.e. diabetes).

(initial)_____ I understand that if my pet is not current on its Rabies vaccination and/or core vaccines (*distemper/parvo for dogs, and feline distemper/leukemia for cats*), the required vaccines will be administered to my pet and the fees added to the invoice.

(initial)_____ I have been informed that there are inherent risks and complications that may be associated with sedation, anesthesia, and/or any operation/surgical procedure. I am encouraged to discuss any concerns I have about these risks with the attending veterinarian before the procedure is initiated. To help minimize this risk, our veterinary team will perform age-appropriate bloodwork prior to the procedure to ensure health of important internal organs prior to performing sedation or anesthesia. We will also place an intravenous (IV) catheter prior to the procedure; this aids in rapid administration of emergency medications and/or fluids in case of arrest during or after the procedure.

(initial)_____ I also understand that, during the course of the procedure, unforeseen circumstances could arise that may necessitate the performance of additional procedures that are in the best interest of my pet's health, safety, and comfort, as deemed important by the attending veterinarian.

(initial)_____ I authorize the use of appropriate anesthesia and pain relief medication as needed before, during, and/or after the procedure. I have been informed of the risks associated with the use of medications. Prices for pain medications depend on the species and weight of the animal.

(initial)_____ I have been informed of Casper Animal Medical Center's payment policies, and understand that full payment for services rendered is expected upon discharge of my pet. I understand that in-house payment arrangements will not be offered, however I will be provided information about payment assistance options – including CareCredit and Scratchpay – upon request.

(initial)_____ The nature of the procedure(s) to be performed have been explained to me, and I understand what will be done. I am aware that the practice of veterinary medicine is not an exact science, and there is no guarantee of successful treatment. I have been encouraged, and given the opportunity to, ask any questions I may have regarding my pet's medical care, and my questions have been answered to my satisfaction. I also understand that my financial obligation remains, regardless of the outcome of the procedure.

(initial)_____ I understand that my pet may be considered abandoned if Casper Animal Medical Center has not been able to make contact with me within 7 days of the expected discharge date. Casper Animal Medical Center is then authorized to dispose of my pet as best deemed, including euthanasia, and I will still be responsible for all charges accrued.

(initial)_____ I am aware that, if my pet needs to stay overnight after their procedure (*including, but not limited to: canine and feline spay, feline declaw, canine gastropexy, and orthopedic surgeries*), they must be picked up no later than 10:00am the following morning to avoid additional hospitalization charges, unless prior arrangements have been made and approved by the attending veterinarian.

DENTAL PROCEDURES ONLY:

(initial)_____ I approve the attending veterinarian to perform dental extractions, dental x-rays, and/or bonded sealant treatments on my pet as deemed necessary and important for their health, safety, and comfort.

****OR****

(initial)_____ I request a phonecall from the attending veterinarian BEFORE dental extractions, dental x-rays, or bonded sealant treatments are performed.

If this option is selected, I verify that I WILL be reachable by telephone at all times today. If I do NOT answer immediately, and the veterinarian or technician leaves a message, I verify I WILL call back within 5 minutes to minimize the time that my pet is under anesthesia while waiting on a response from me. If I do not return the call within 5 minutes, the veterinarian has my permission to perform whatever procedure(s) are in the best interest of my pet's health, safety, and comfort, and I will still be responsible for any and all associated charges.

ADDITIONAL OPTIONS FOR ALL SURGERIES:

Post-operative Therapeutic Laser Treatment: \$14.25 – strongly recommended after general surgeries (*spay, neuter, feline declaw, canine gastropexy, etc.*), orthopedic surgeries, and dental procedures - helps decrease pain/inflammation of surgical sites and dental extraction sites, and can decrease healing time by promoting cell regeneration; **NOT recommended after removal of masses that are potentially cancerous**

(initial)_____ Accept ****OR**** (initial)_____ Decline

Microchip implant: \$45.00 (regular price \$67.75) – permanent identification; microchip is approximately the size of a grain of rice, and is implanted deep in the muscle under the shoulder blade; NOT a GPS location device

(initial)_____ Accept ****OR**** (initial)_____ Decline

Canine Heartworm Test: \$38.00 – recommended annually for all dogs over 6 months of age, ideally performed in the springtime; heartworms are transmitted by mosquitoes when a mosquito bites a heartworm-positive dog, and then bites another dog; the test entails a small blood draw, and a few drops of blood placed onto a test strip

(initial)_____ Accept ****OR**** (initial)_____ Decline

Canine Heartworm prevention (Interceptor Plus®): price varies by quantity dispensed and weight of dog – advised after heartworm testing to prevent heartworm disease and provide broad-spectrum intestinal deworming; given as a once-a-month, beef-flavored, chewable tablet; minimum recommendation is 6 months (June thru November)

(initial)_____ 6 months ****OR**** (initial)_____ 12 months ****OR**** (initial)_____ None

In the event that your pet should experience cardiac or respiratory arrest while in our care for their procedure, do you consent to resuscitative measures being initiated until you can be contacted further and notified of their status?

(initial)_____ I agree to CPR (cardio-pulmonary resuscitation) in case of arrest. If selected, please note that an IV (intravenous) catheter WILL be pre-placed; this allows us immediate access to a vein for administration of emergency medications or fluids.

****OR****

(initial)_____ I elect a DNR (DO NOT RESUSCITATE) in case of arrest.

Please indicate ONE best contact person, and ONE best contact phone number where we can reach you **at all times today** for questions or updates. This person will also be the emergency contact while your pet is in the hospital today, and will be responsible for communicating updates to any other interested parties.

In the event of an emergency, we cannot and will not attempt to call multiple phone numbers, so please only indicate ONE designated contact person.

Contact person: _____

Contact phone #: (____) _____ - _____

(initial)_____ **To allow our doctors and staff to give ALL patients in our hospital today our best care and full attention, we kindly request you PLEASE wait for us to contact you with updates on your pet.**

My signature below indicates I have read and understand this authorization, and accept and agree to the terms of the consent for treatment.

Signature: _____

Printed Name: _____

Date: ____/____/20____