ANESTHESIA/SURGERY CONSENT

<last-name>, <first-name> "<animal>" <species>, <breed>,<color> DATE_____

Best Contact # (_____) _____ Alternate phone # (____) _____
For Today between 8am – 6pm

All pets must be current on vaccinations (Rabies, DHLP PV, FVRCP) Bordetella is recommended for dogs. All pets will be given a capstar at admission to insure they are free of fleas at 0wners expense.

☐ Spay (if in heat, additional charge) ☐ Neuter (if cryptorchid, additional charge)

☐ Dental (extractions additional) ☐ declaw front / all four (circle one)

☐ Growth removal (mark growths to be removed on next page) ☐ Other_____

The Doctor will make an assessment of the pain involved and implement a pain medication plan.

Required Pre-Surgical Blood Work (up to 23 months recommended)

Profile # 1 2-5 yrs.	**Profile # 2 6 yrs and older**
Kidney (BUN & Creatinine)	**Complete Blood Count**
Liver (ALT & ALK Phos)	**Complete Organ Profile:**
Blood Sugar (Glucose)	**Kidney profile (BUN, Phosphorous, Creatinine)**
Total Protein	**Calcium (indicates some tumors & endocrine system**
	Total Protein & Albumin indicates acute/chronic Disease

Patients under 2 yrs of age recommended labwork
I want the following blood test: Profile # 1☐ Profile # 2☐ Outside Lab on _____
I decline the recommended blood work and request that you proceed with the anesthesia _____(initials)

Heartworm Test ☐Y /☐ N (check one) Feline Leukemia / Feline Aids (FIV) ☐ Y /☐ N (check one)

IV Fluids during Surgery – Intravenous fluids during surgery help to maintain normal blood pressure and allow rapid administration of drugs should an emergency situation develop. We will shave a small area for IV placement. Your pet will receive intravenous fluids during the anesthetic period, which will provide for safer anesthesia and a quicker recovery.

MICROCHIP IMPLANT Implant microchip ☐ Decline microchip ☐

I understand that anesthesia involves risks and hazards in addition to those involved with the recommended surgical, medical or diagnostic procedure. I understand that no guarantee or warranty has been made regarding the results or cure. I will be called at the number listed should the doctor find the procedure(s) to be more involved or additional procedures to be required. If I cannot be contacted, I authorize the doctor to perform the necessary procedure. **I agree to assume financial responsibility and provide payment in full when the patient is discharged. We accept CASH, CREDIT CARDS (Visa, Mastercard, Discover, CareCredit) or check with proper identification. I have read fully and understand the terms and conditions set forth above. _____ (initial)**

Signature of owner or authorized agent _____Date _____