

SURGERY CONSENT FORM



DATE : _____

CLIENT: _____

PATIENT: _____

I am the owner or agent for the animal described above and I have the authority to execute this consent. I hereby consent and authorize Piper Creek Veterinary Clinic to perform the following procedures or operations:

- | | | | | |
|--|------------------------------------|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> General Anesthesia | <input type="checkbox"/> Spay | <input type="checkbox"/> Neuter | <input type="checkbox"/> Laser | <input type="checkbox"/> Microchip |
| <input type="checkbox"/> Tattoo | <input type="checkbox"/> Nail Trim | <input type="checkbox"/> Front Declaw | <input type="checkbox"/> Front/Hind Declaw | |
| <input type="checkbox"/> Anal Glands | <input type="checkbox"/> Pain Meds | <input type="checkbox"/> X-Rays | <input type="checkbox"/> Dental | <input type="checkbox"/> IV Fluids |
| <input type="checkbox"/> Other Procedure _____ | | | | |
| <input type="checkbox"/> Distemper/Parvo Combination | <input type="checkbox"/> Rabies | <input type="checkbox"/> Bordetella | | |

The nature of these operations has been explained to me and I understand what will be done. I have also been informed that there are certain risks and complications associated with any operation or procedure of this type. I realize there can be no guarantee as to the outcome of any procedure and have been advised of the possible risks involved. In after hours/emergency situations, anesthetic monitoring is usually performed by the veterinarian performing the procedure. All precautions are taken to ensure the safety of the patient at all times. If unexpected health problems arise, I grant permission to do any treatments and procedures as they deem necessary, should they be unable to contact me at the above number. I understand that I assume financial responsibility for all services rendered and that payment is due at the time of discharge, unless special arrangements have been made prior to discharge. **All animals entering the hospital must be free of external parasites or they will be treated at the owner's expense.** All animals must be vaccinated, and if not, Piper Creek Vet Clinic assumes no responsibility for treatment of unvaccinated animals should they become ill. **PLEASE NOTE IF YOUR CANINE IS OVER A YEAR OF AGE, AND/OR PREGNANT, OR IN HEAT THERE IS AN ADDITIONAL CHARGE**

I have read and understand this authorization and consent.

Signature _____ Date _____ Contact Phone Number _____

_____(initial) I refuse recommended immunizations or to provide documentation of current immunizations at this time, and request that you proceed with the above stated procedures. I understand that my pet is at risk of contracting a communicable disease and I accept full financial responsibility

Pre-Anesthetic Blood Testing Consent Form \$105.20

Like you, our greatest concern is the well being of your pet. Before putting your pet under anesthesia, we will perform a full physical examination. However, we recommend a pre-anesthesia blood profile to be performed in order that we may maximize patient safety and alert the doctor to the presence of dehydration, diabetes, kidney or liver diseases that could complicate the procedure. These tests are similar to tests that your physician would run were you to undergo anesthesia. In addition, the results of these tests may be useful later to develop faster, more accurate diagnoses and treatments in the event that your pets health changes. State of the art equipment enables us to perform the pre-anesthetic blood profile within the clinic.

_____(initial) please complete the blood work recommended prior to surgery on my pet. If abnormalities are found please contact me at the above phone number.

_____(initial) I have elected to refuse the recommended blood work at this time and request that you proceed with the anesthesia. I assume full responsibility for this animal.