



Randall Orchard Crossing Animal Hospital

1045 Orchard Road, North Aurora, IL 60542

Phone: (630) 723-6369 Fax: (630) 618-4824

ANESTHETIC, SURGICAL AND MEDICAL CONSENT

Owner's Name: _____ Date: _____

Pet's Name: _____ Species: _____ Breed: _____ Sex: _____ Age: _____

Procedure(s): _____ fasted? Yes / No

Today's Weight: _____ LBS Additional Notes: _____

Please read carefully!

Pre-Anesthetic Blood Testing:

We test our patient's blood to detect dehydration, anemia, infection, diabetes, liver and kidney disease. This is done to avoid complications with your pet during surgery or while they are anesthetized.

Done on: _____

Needs to be done today: _____

IV Catheter/ Intravenous Fluids:

We administer fluids through an IV catheter during anesthetic procedures to help support the circulatory system, maintain blood pressure, prevent dehydration, and help your pet recover more quickly from anesthesia. IV access also allows us to administer medications more quickly in case of an emergency.

Procedures to be done Concurrent with Procedure:

- | | | |
|--|---|---|
| <input type="checkbox"/> Vaccines: _____ (\$ Varies) | <input type="checkbox"/> Ear Cleaning / Plucking (\$20) | <input type="checkbox"/> Extractions (Call First) Yes / No |
| <input type="checkbox"/> 4DX Test (\$47) | <input type="checkbox"/> Anal Gland Expression (\$25) | <input type="checkbox"/> Owner's initials _____ |
| <input type="checkbox"/> Fecal (\$43) | <input type="checkbox"/> Nail Trim (Complementary) | <input type="checkbox"/> Oravet Application (\$35) |
| <input type="checkbox"/> Microchip Implantation (\$40) | <input type="checkbox"/> E. Collar (Complementary) | <input type="checkbox"/> Add on Package (Rescues) (\$120) |
| <input type="checkbox"/> Add on Dental (\$250+) | <input type="checkbox"/> Convenia Inj. (\$40-\$200) | <input type="checkbox"/> Add on Meds (Rescue) (\$ varies) |
| <input type="checkbox"/> Biopsy (\$ Varies) | <input type="checkbox"/> Yesterday's News (\$12-\$32) | |

Please note: Hospital policy requires **immediate treatment** for fleas at the owner's expense if any are found on hospitalized pets. Treatment may include using oral and/or topical treatments.

If your pet is not up to date on required vaccines or heartworm test with proof, they will be done at owners cost. All alteration surgeries (spay/neuter) will receive a "tattoo" indicating they are altered.

Medications: Pain Medication and Antibiotics will be prescribed at the Doctor's discretion.

I, the undersigned, certify that I am the owner, or authorized agent for the owner, of the animal described above. I authorize the doctor(s) on duty and assistants to perform the procedures listed above including the administration of pain relief medications, sedatives and/or anesthetics, as well as any necessary and appropriate medical, radiological, surgical, nursing, diagnostic, and/or emergency care for the animal. I understand that **extractions range from \$25-\$150 PER tooth**. I understand that the procedure(s) may involve risk of complications, injury, or even death, from both known and unknown causes, and that no warranty or guarantee has been either expressed or implied as to a result or cure.

Furthermore, I authorize the hospital staff in an emergency situation, to follow through with such procedures as are necessary for the well being of my pet on a continuing basis until further communication with me. I agree to assume financial responsibility for all routine and emergency services rendered. **CPR: YES NO**

Your signature below constitutes your acknowledgement that **(1)** you have read and agreed to the above, **(2)** the procedure(s) have been explained to your satisfaction and you have all the information that you desire, and **(3)** you authorize and consent to the administration of anesthesia and performance of the indicated procedure(s).

Signature: _____ Date: _____ Emergency Phone: (_____) _____