



Warren Woods Veterinary Hospital

29157 Schoenherr Road

Warren, MI 48088

Telephone: 586-751-3350 Fax: 586-751-3447

Surgical Consent Form for Growth Removal

Patient: _____ Owner or Responsible Party: _____

Like you, our greatest concern is the wellbeing of your pet. Your pet is scheduled for anesthesia and/or surgery. Before putting your pet under anesthesia, we will perform a full physical examination. We will also run a pre-anesthetic blood profile to maximize patient safety and to alert the doctor to the presence of dehydration, diabetes, kidney, and/or liver disease that could complicate the procedure. These conditions may not be detected without the aid of blood work. These tests are similar to those your own physician would run if you were to undergo surgery.

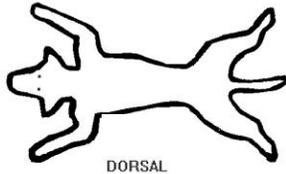
It is our recommendation to have all growths sent for histopathology. The histopathology helps better diagnose the growth as either benign or malignant. This tool can help the doctor in determining the best treatments for your pet. Please circle one:

HISTOPATHOLOGY \$219.50-\$450.00

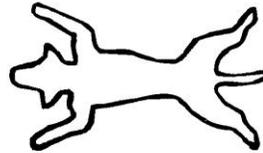
APPROVE **DECLINE**

Please tell us how many growths and their locations so we can properly remove the growth needed.

Qty: _____



DORSAL



VENTRAL

It is important for your pets surgical healing, therefore an e-collar is recommended to prevent your pet from prolonged pain and trauma. Please circle one:

ECOLLAR \$21.00

APPROVE **DECLINE**

If there are any additional procedures or treatments you would like done concerning your pet. Please write them here:

I authorize the above named surgical procedure to be performed at Warren Woods Veterinary Hospital. The nature of such service has been described to me to my satisfaction and I realize that no guarantee can ethically or professionally be made regarding the results or cure. I understand that I assume financial responsibility for all services rendered. While your pet is resting comfortably during the night, there will not be any medical supervision. If your pet needs 24 hour care, your doctor will discuss treatment options with you. **I have provided proof that my pet has been vaccinated against rabies or I authorize Warren Woods Veterinary Hospital to vaccinate my pet for rabies.**

Signature _____ Date _____

Phone number(s) where you can be reached today: Home: _____

Cell: _____

Is there anything else we should know about your pet? _____

Is your pet on any medications? _____

If you will not be picking up your pet please state here who you give authorization to pick them up: _____

Rev. 1/19

Scanned into Avimark (date/initials) _____