



Animal
Care
Clinic

Surgical & Anesthesia Consent Form

Owner's Name: _____ Date: _____

❖ **Phone Number** where you can be reached **today**: _____

Address: _____

Pet's Name: _____ Pet's Age: _____

I certify that I own, or have authorization over, the above-described animal. I do hereby consent and authorize the Animal Care Clinic and its staff to hospitalize my pet and to administer vaccinations, medications, tests, surgical procedures, anesthetics or treatments that the doctors deem necessary for the health, safety and well-being of the above animal while it is under their care and supervision.

*****Please initial selected procedures you would like your animal to have***
Fees for selected procedures will be added to surgical cost.**

_____ I request full bloodwork (CBC & Surgical Profile) prior to surgery *\$108.00

_____ I request a Surgical Profile prior to surgery *\$53.00

_____ Yes, I would like a Feline Leukemia/FIV test performed on my cat prior to surgery *\$41.00

_____ Yes, I request a Microchip for my animal *\$37.50 (email: _____)

_____ **I waive the request of a CBC and/or Profile**

The following surgical procedure and/or treatment will be performed on my pet:

❖ Young dogs and cats may have retained baby teeth which will interfere with the growth of the adult teeth and/or lead to other problems. While your pet is under anesthesia, we can remove any retained baby teeth.

I realize that I am responsible for payment at the time of discharge for the above procedures and treatments.

Please choose which of the following payment options you will be using:

CASH _____

CHECK _____

CREDIT OR DEBIT CARD _____

I understand that there are risks involved with treatment and surgical procedures such as my pet may injure itself, refuse food, become ill, or die while in the hospital. I will not hold the Animal Care Clinic and staff responsible and/or liable, in the absence of gross negligence. I also understand that my pet may get 'soiled' while in the clinic for certain procedures despite the staff's efforts to avoid this.

Signature of person authorized to consent for patient: _____ Date: _____