



# Animal Care Clinic

Dr. Robin O'Neill  
1315 6<sup>th</sup> Ave SE, Ste 3  
Aberdeen, SD 57401

# Procedural Consent Form

Owner's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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 administer and complete any/all tests and treatments agreed upon, that the doctors deem necessary for the health, safety and well-being of the above animal while it is under their care and supervision.

**\*\*\*For anesthetic procedures, please check any optional lab work you would like your pet to have\*\*\***

\_\_\_\_\_ Full bloodwork (CBC & Surgical Profile/lyte) prior to surgery \*\$130.00

\_\_\_\_\_ Partial bloodwork (Surgical Profile/lyte only) prior to surgery \*\$75.00

\_\_\_\_\_ Feline Leukemia/FIV test (felines only) prior to surgery \*\$50.00

**OR**

\_\_\_\_\_ **I decline any pre-anesthetic lab work being done on my pet**

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

\_\_\_\_\_

I would like my pet to have an e-collar(cone) for the recovery phase (fee applicable) :    \_\_\_yes\_\_\_no    (please initial one)

I request a Microchip for my animal \*\$37.50 (email: \_\_\_\_\_)    \_\_\_yes\_\_\_no    (please initial one)

I agree to pain medication being prescribed, if deemed necessary. (fee applicable):    \_\_\_yes\_\_\_no    (please initial one)

***I understand that I am financially responsible for the above procedures and treatments as discussed and agreed upon in the ESTIMATED charges of \$\_\_\_\_\_.  
PAYMENT IS DUE AT THE TIME OF DISCHARGE (initial: \_\_\_\_\_)***

***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, vomit/have diarrhea, 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: \_\_\_\_\_

.....  
(At discharge) I have received and reviewed the discharge instructions: \_\_\_\_\_