



POWHATAN
ANIMAL HOSPITAL

Owner: _____ Acct. _____ Date: _____

Cell Phone: _____ Home Phone: _____

Patient: <animal> <sex> <breed> <age> <color>

Reason for visit: _____

Surgical Consent Form

Patient information:

Vomiting? yes / no Diarrhea? yes / no

Is your pet taking any medications? (if so please list) _____

If yes when was the last dose given _____

Any illness or injury in the last 30 days? _____

Any allergies to medications? _____

Did your pet eat this morning? No Yes At what time? _____

Elective Procedures:

Microchipping Express Anal Glands Nail Trim

Pre-Surgical Blood Profile: Blood work is recommended prior to your pet’s surgery, dentistry or other procedures that require anesthesia &/or sedation. This alerts the veterinary staff if there are any abnormal liver, kidney and other internal organ values and allows them to make adjustments. Blood tests do not alert the veterinary staff if your pet may be allergic to anesthetic drugs or to other complications.

YES, I would like the blood panel performed on my pet prior to surgery at an additional cost.

NO, I decline the blood panel and have been informed of the risk involved.

Pain management:

Pain medication injection: NOT OPTIONAL FOR ORTHOPEDIC AND DECLAW PROCEDURES.

YES, I would like my pet to receive an injection for pain relief.

NO, I decline the pain injection.

Pain medication to go home with your pet after surgical procedure: NOT OPTIONAL FOR ORTHOPEDIC AND DECLAW PROCEDURES.

YES, I would like my pet to receive pain medication to go home.

NO, I decline the pain medication to go home.

Dental Procedure

Dental

The procedure would require your pet to undergo general anesthesia. It includes ultrasonic scaling and polishing. In the event that dental extractions are recommended, we will attempt to contact you. If extractions are needed and you cannot be reached:

YES, perform extractions as needed. **NO**, do not perform any extractions without my consent.

- There will be additional charges at the owner's expense if your pet is pregnant, cryptorchid, or if surgery time is extended due to complications.

Hospitalization /Treatment Consent:

I certify that I own/have assumed financial responsibility for the above-described animal. I do hereby consent and authorize the Powhatan Animal Hospital and its staff to hospitalize this animal, and to administer vaccinations, medications, tests, surgical procedures, anesthetics or treatments that the doctors deem necessary for the health, safety, or well-being of the above animal while it is under their care and supervision. Veterinary services during nighttime hours, and/or weekends, are provided at the discretion of the veterinarian in charge. Continuous presence of personnel may not be provided during these hours. If the animal should injure itself in an escape attempt, refuse food, soil itself, become ill, or die while in the hospital, I will hold the Powhatan Animal Hospital free of any responsibility and/or liability in the absence of gross negligence. I further realize that I am responsible for the payment of the above procedures and treatments in full at the time the animal is discharged.

Pets must be free of internal and external parasites, such as fleas, ticks, and intestinal parasites, as they are transmissible to other pets. If present, treatment will be given at the owner's expense.

Name: _____

Date: _____

Signature: _____

Phone Numbers where you can be reached today:

Primary contact number/name: _____

Secondary contact number/name: _____

Staff Initials: _____