

SIGNED AUTHORIZATION FOR MEDICAL/SURGICAL TREATMENT

Canine

Patient's name _____

Owner's name _____

Phone number(s) where we can reach you during surgery

K9 REQUIRED: EXAM current or needed
K9 REQUIRED: DHPP current or needed
K9 REQUIRED: BORD current or needed
K9 REQUIRED: RABIES current or needed
K9 Recommended: CIV current or declined

Surgical Procedure

- Ovariohysterectomy/spay (female)
Simple extraction(s) Accept or Decline
- Castration/neuter (male)
Simple extraction(s) Accept or Decline
- Dental prophylaxis
Simple extraction(s) Accept or Decline
- Identification Microchip
 Already has Accept or Decline
- Mass Removal

Location: _____

- Abscess/laceration

Location: _____

- Other _____

Medical History

Are there any medical conditions regarding your pet that you'd like us to know about? Yes No

The estimate reflects uncomplicated, routine procedures. If your pet is pregnant, in heat, or obese an extra fee may be charged to reflect additional surgical time. If your pet is found to have fleas, medication will be administered and a fee will be charged.

Initial _____

Some medications are available in different forms. If antibiotics or pain medicines are required to be sent home, which do you prefer?

- Liquid or Tablets or No Preference

What time did your pet eat last? _____ Diet: _____

Has your pet had any medication(s), supplements, or flea medications in the last 24 hours? Y or N

If yes; which? _____

At what time? _____

Do you need a refill of any medications:

I understand that it is my responsibility to ensure the health and safety of my pet after surgery. This may require the use of restraint devices, such as an Elizabethan Collar, or harness to allow for mobility. These items are designed to prevent damage and protect the surgical site. A device will be recommended at the Doctor's discretion, I agree to use the device until otherwise directed.

Initial _____

Anesthetic Safety Screening: I understand that anesthesia/surgery carries some risk. Complete blood work checks proper organ functions needed to clear the anesthetic medications, oxygen carrying ability of blood, ability to fight infection, platelets for proper clotting, and to establish a baseline for future reference. Current bloodwork is required for all anesthetic procedures. See estimate for doctor recommended bloodwork for your pet.

Post-Operative pain medicine may be administered at the Doctor's discretion. This may be in addition to the estimate.

I am aware of the risks from this procedure and understand the information presented in this surgery form. I give West Salem Animal Clinic and staff permission to proceed with the surgery. Should the unanticipated need arise for life saving measures I give permission for WSAC to perform CPR and any and all life-saving procedures understanding that there is a fee associated with this.

Initial: _____

OR

I need to be contacted before WSAC performs **extensive** life-saving procedures and do not want my pet resuscitated. Understanding that if I am unavailable to be contacted I allow West Salem Animal Clinic to make decisions regarding my pet.

Initial: _____

I understand that all fees are due upon release of patient.

Client Signature: _____ Date: _____

WSAC Employee: _____