



# Stafford Animal Hospital Treatment/Surgery Consent Form

Client Chart No.: \_\_\_\_\_

Name: \_\_\_\_\_ Treatment/Surgery Date: \_\_\_\_\_

Address: \_\_\_\_\_

Pet Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Treatment or surgical procedure to be performed: \_\_\_\_\_

Please read carefully and sign.

### Required Vaccinations

- My pet is up-to-date on vaccinations that were administered by a Licensed Veterinarian and I have provided a copy to SAH for my records.
- Please administer the following vaccinations \_\_\_\_\_
- I would like my pet microchipped: Please circle Yes or No \_\_\_\_\_ Initial \_\_\_\_\_

### Sedation/ Anesthesia/Pain Medication

- I authorize Stafford Animal Hospital to administer sedation or anesthesia, as necessary, to treat my pet.
- I authorize the veterinarian to use his/her discretion concerning pain medication.

### Pre-anesthetic blood work

We **highly recommend** a blood profile before anesthesia and surgery to ensure that your pet is in a low-risk category. The latest technology lets us run safe, accurate blood chemistries minutes before anesthetic induction. These tests are similar to those your own physician would run were you to undergo anesthesia. In addition, the results of these tests will serve as reference values for future use should your pet become ill. Please see the highlighted tests below which our veterinarian recommends for your pet prior to anesthesia. These tests can point out potential problems, but even with these test results in hand the element of risk remains.

- I request full blood work (**available** for all pets, **mandatory** for pets with health issues or pets 1 and older). \$ \_\_\_\_\_
- I request minimum blood work (**available** for healthy under 1 year old or per Doctor instructions). \$ \_\_\_\_\_

I understand that some risks always exist when administering vaccines, medication, and/or anesthesia as well as performing surgery. I have been encouraged to discuss any concerns I have with the attending veterinarian before the procedure(s) is/are initiated. While I accept that all procedures will be performed to the best of the abilities of the staff at this hospital, I understand that no guarantee or warranty has been made regarding the results that may be achieved. Should my pet have an adverse reaction to the procedure(s) as indicated on this form, I authorize Stafford Animal Hospital to perform any medical procedures as necessary (in the veterinarian's professional judgment) for my pet's well-being. I understand that every effort will be made to contact me prior to the treatment; however, if they are unable to reach, treatment will not be withheld and I assume responsibility for all costs incurred.

I, the undersigned, as owner or agent for the owner of the pet identified, authorize the veterinarian and staff at Stafford Animal Hospital to perform the above procedure(s). My signature on this form indicates that any questions I have regarding the procedure(s) have been answered to my satisfaction. I agree to assume financial responsibility and provide payment via cash, credit card, or check. I have read fully and understand the terms and conditions set forth.

\_\_\_\_\_  
Signature of owner or authorized agent ( 18 yrs or older):

\_\_\_\_\_  
Date