NEWTON ANIMAL HOSPITAL

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Newton, KS 67114
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reception@newtonanimalhospital.org

Anesthesia/Surgery Consent Form

Client Name: _____
Address: _____
_____
City, State, Zip _____
Telephone: _____

Pet Name: _____
Breed: _____
Sex: _____
Color: _____
Markings: _____
Birth Date: _____

I am the owner or agent for the owner of the above described animal, I am over 18, and I have the authority to execute this consent. I hereby consent and authorize the following procedures(s) or operation(s):

_____

I UNDERSTAND that during the performance of the foregoing procedure(s) or operation(s), unforeseen conditions may be revealed that necessitate an extension of the foregoing procedure(s) or different procedure(s) than set forth above. Therefore, I hereby consent to and authorize the performance of such procedure(s) or operation(s) as are necessary and desirable in the exercise of the veterinarian's professional judgment.

I ALSO AUTHORIZE the use of appropriate anesthetics, and other medications, and I understand the clinic support personnel will be employed as deemed necessary by the veterinarian.

I HAVE BEEN ADVISED as to the nature of the procedure(s) or operation(s) and the risks involved. I realize that the results cannot be guaranteed.

I UNDERSTAND, if my pet is found to have fleas, he/she will be treated for fleas, at my expense.

Occasional problems can arise, due to pre-existing conditions not evident during routine pre-surgical examinations. We recommend that all surgical cases be screened prior to surgery. All surgical cases should have a pre-surgical blood prep panel, electrolytes, & CBC.

********** **PLEASE RESPOND TO EACH STATEMENT BELOW:** **********

☐ I DO / ☐ DO NOT want presurgical screening performed on my pet, ($70.00)
☐ I DO / ☐ DO NOT want a pet identification microchip implanted in my pet-includes 1 year membership in the Home Again Recovery System ($65.00)
☐ I DO / ☐ DO NOT want laser treatment to assist with post-operative healing. ($11.00)
☐ I DO / ☐ DO NOT want to have my pet's nails trimmed while under sedation. ($5.50)
☐ I DO / ☐ DO NOT want diseased, damaged, or retained baby teeth removed during the procedure (at an additional fee).

DENTAL PROCEDURES ONLY - Please contact me if the price of the dental services will be over $_____.

I HAVE READ AND UNDERSTAND THIS AUTHORIZATION AND CONSENT.

_____ _____ / _____
Date Signature of Owner or Agent / Phone # where I can be reached

Signature of Witness: _____