

HIGHLANDS RANCH ANIMAL CLINIC
38 W. SPRINGER DRIVE
HIGHLANDS RANCH, CO 80126

ANESTHESIA/SURGERY CONSENT FORM

Owner's Name: _____ Patient's Name: _____

- 1) I hereby authorize Dr. _____ and whomever she may designate as her associates to perform the following procedure(s) or operations: _____ .
- 2) It has been explained to me that conditions may arise during this procedure whereby a different procedure or an additional procedure may need to be performed and I authorize my veterinarian to do what is needed and necessary to provide the proper care of my pet.
- 3) I have been advised as to the nature of the procedure and the risks involved. I understand that complications including, but not limited to, infection, cardiac arrest, and death could result. I acknowledge that no guarantee has been made as to result or cure.

Pre-Anesthetic Blood Testing: Our greatest concern is the well being of your pet. Before putting your pet under anesthesia we will perform a physical examination. However, many conditions, including disorders of the liver, kidneys and blood may not be detected unless blood testing is performed. Such tests are especially important before anesthesia. For these reasons we strongly recommend that all patients receive a blood screen before such procedures. The total cost of these important tests is \$_____.

___YES, I want my pet to have a blood screen performed prior to anesthetic administration.

___NO, I decline this blood screen and have been informed of the risk involved to my pet's health.

Microchip Identification System: A microchip implanted just under your pets skin near the shoulders, contains a permanent identification number. After a veterinary staff member or shelter scans your animal, they can call the 800 number, available 24 hours a day, 7 days a week. The recovery service will provide important identification information about your animal.

___YES, I want my pet to have a microchip implanted. I am aware there is an additional enrollment fee.

___NO, I decline.

Additional Information

Does your pet have a history of seizures? _____Yes _____No

Has your pet been fasted from food for at least a 12-hour period? _____Yes _____No

Does your pet have any allergies to any medications? _____Yes _____No

Any other concerns before surgery? _____

Owner's Signature: _____ Date: _____

Phone # where we can reach you today** : _____

** It is imperative that we have a phone number to reach you at throughout the day. We will be unable to perform essential tooth extractions if we cannot reach you by phone. Extraction surgery will then have to be rescheduled.