

**SURGERY AUTHORIZATION AND CONSENT**

**PIEDMONT VETERINARY CLINIC**

<b>OFFICE USE ONLY</b>		
Date _____	Patient Name _____	Last Name _____
Procedure _____		Owner's initials (indicate consent to named procedure for above pet) _____

Pre-Surgical Information (IMPORTANT- **Please initial** that you have read each line and note ALL medications):

\_\_\_\_ Patient has not eaten anything after 10 pm the night before operation.

\_\_\_\_ Is your pet on Heartworm Prevention monthly? \_\_\_\_ YES \_\_\_\_ NO

\_\_\_\_ Is your pet on Flea and/or Tick preventative monthly? \_\_\_\_ YES \_\_\_\_ NO

**NOTE: If fleas and/or ticks are seen, a flea/tick product will be applied or given by mouth.**

\_\_\_\_ Is your pet on ANY medications? \_\_\_\_ YES \_\_\_\_ NO

**Please list ALL medications:**

- |                    |              |                       |
|--------------------|--------------|-----------------------|
| 1. Drug Name _____ | Dosage _____ | Last dose given _____ |
| 2. Drug Name _____ | Dosage _____ | Last dose given _____ |
| 3. Drug Name _____ | Dosage _____ | Last dose given _____ |

\_\_\_\_ Does your pet have any known allergies? \_\_\_\_ YES \_\_\_\_ NO If yes, explain: \_\_\_\_\_

Please INITIAL ONLY if you are consenting to each recommendation below. These items will be at an additional cost unless otherwise specified.

\_\_\_\_ I hereby authorize and direct the veterinarian to perform CPR (cardiopulmonary resuscitation) and other life saving measures in case of an emergency.

\_\_\_\_ I hereby authorize the veterinarian to extract any teeth deemed medically necessary, including retained deciduous ("baby") teeth.

\_\_\_\_ I acknowledge that the veterinarian will administer pain relief medication pre- and post-operatively.

\_\_\_\_ I authorize disposal of tissues (at no additional charge) removed at surgery not required for further testing.

\_\_\_\_ I would like my pet to be protected with a **ResQ Microchip**. This is a microchip placed under your pet's skin with a hypodermic needle for permanent identification. **Cost:\$55.00**

I acknowledge that the veterinarian/staff member has discussed the importance and benefits of performing pre-anesthetic bloodwork to aid in designing the appropriate anesthetic protocol for my pet. **Bloodwork is not optional for some patients, see doctor's requirements for anesthesia.** (Please initial one choice below):

- \_\_\_\_ I have already had bloodwork run on my pet.
- \_\_\_\_ YES, I do want my pet to have pre-surgical bloodwork.
- \_\_\_\_ NO, I do not want my pet to have pre-surgical bloodwork.

I understand the above anesthetic and surgical, diagnostic or therapeutic procedures may involve risk of complications, injury or even death, from both known and unknown causes and no warranty or guarantee has been either expressed or implied as to result or cure. Furthermore, I authorize the hospital staff in an emergency situation, to follow through with such procedures as are necessary for the well being of my pet on a continuing basis until further communication with me. I agree to assume financial responsibility for all routine and emergency services rendered.

Your signature below constitutes your acknowledgement that (i) you have read and agreed to the above, (ii) the procedure(s) have been explained to your satisfaction and that you have all the information that you desire, (iii) you have had the chance to ask questions, and (iv) you authorize and consent to the performance of the procedure(s) and to the administration of anesthesia.

Owner's Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

Phone number with area code where you can be reached today: (\_\_\_\_\_) \_\_\_\_\_

<b>OFFICE USE ONLY</b>
Post-Op Call
_____ initials
_____ time
_____ TGH time

**NOTE: It is very important that we are able to reach you at all times while your pet is in the clinic for a surgical procedure.**