

## Procedure Consent Form

Patient: \_\_\_\_\_ Procedure: \_\_\_\_\_

Client: \_\_\_\_\_ CID: \_\_\_\_\_ Date: \_\_\_\_\_

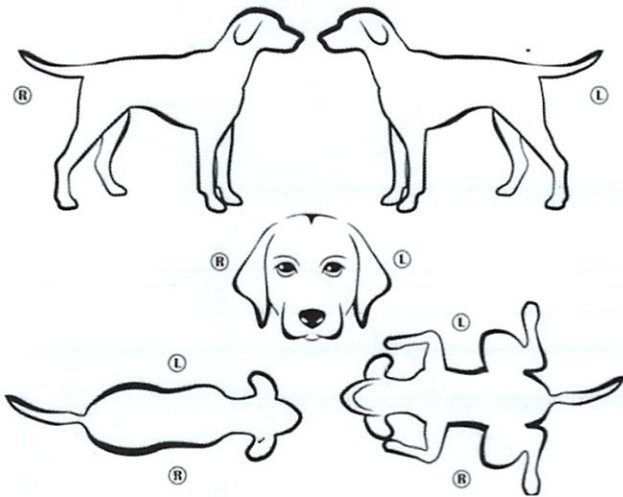
### Lab Work

- Required today \_\_\_\_\_ (initial)       I decline lab work \_\_\_\_\_ (initial)
- Completed on: \_\_\_\_\_       Other: \_\_\_\_\_

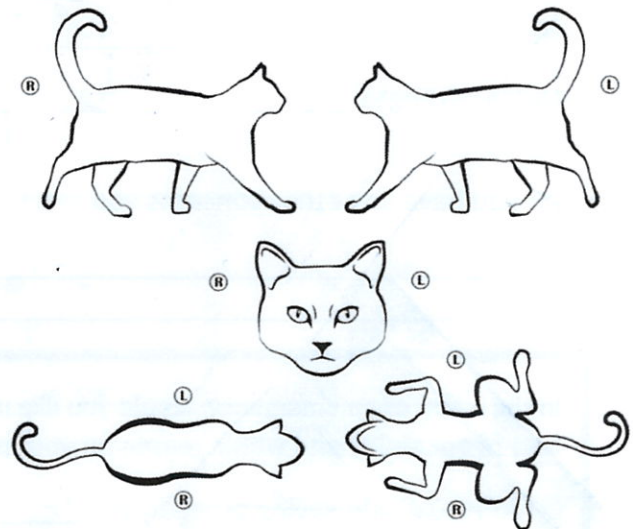
### Growth Removal

If your pet is having any growths removed today, please indicate the location(s) below:

**Canine Body Map**



**Feline Body Map**



### Dental Procedure

- I **APPROVE** full mouth radiographs \_\_\_\_\_ (initial)
- I **APPROVE** extractions as necessary \_\_\_\_\_ (initial)
- I request a call prior to any extractions above and beyond estimate \_\_\_\_\_ (initial)  
(If you select this option and **CANNOT** be reached by the doctor, we may not be able to perform any recommended extractions & another procedure may be required)

### Microchipping

- My pet is already microchipped.       I **APPROVE** microchipping my pet \_\_\_\_\_ (initial)
- I **DECLINE** microchipping my pet \_\_\_\_\_ (initial)

**CONTINUED ON BACK -**

**Pre-Surgical Information**

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When did your pet last:

EAT? \_\_\_\_\_ DRINK? \_\_\_\_\_ URINATE? \_\_\_\_\_ DEFECATE? \_\_\_\_\_

If your pet is an **intact female**, when was their last heat cycle? \_\_\_\_\_

Have you observed any recent **COUGHING, SNEEZING, VOMITING, or DIARRHEA?** If so, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Is your pet on any **MEDICATIONS, PREVENTATIVES, or SUPPLEMENTS?**

Name/Strength: \_\_\_\_\_ Time last given: \_\_\_\_\_

Name/Strength: \_\_\_\_\_ Time last given: \_\_\_\_\_

Do you have any other concerns you would like to mention to the doctor today?

\_\_\_\_\_  
\_\_\_\_\_

**In the event of an emergency, would you like us to perform necessary life-saving procedures to the best of our ability and within reason for your pet?**

I **APPROVE** life-saving procedures \_\_\_\_\_(initial)

I **DECLINE** life-saving procedures and request a DNR form \_\_\_\_\_(initial)

**By signing below, you agree to the following.**

***You MUST be available by phone during the procedure. Payment is due at the time of services. You are authorized to consent and have received necessary explanations of the treatments being provided. You understand that there are no guaranteed results of these treatments, and you will not hold our hospital, doctors, and staff liable for undesired or unexpected outcomes.***

Owner signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number *(must be available during procedure)*: \_\_\_\_\_

Alternate Phone Number *(must be available during procedure)*: \_\_\_\_\_