HEIGHTS VETERINARY CLINIC
pet doctors in practice. pet lovers at heart.

Anesthetic Consent Form

Client: _____Patient: _____

I hereby authorize the performance of the following procedure(s) or operation(s) with the appropriate anesthetics and medications:

_____

_____

The nature of such service has been described to me to my satisfaction and I understand the risks involved. I realize that no guarantee, nor warranty, can ethically or professionally be made regarding the results. I understand that during the performance of the foregoing procedure or operation, unforeseen conditions may be revealed that necessitate an extension of the foregoing procedure or operation than those set forth above. Therefore, I hereby consent to and authorize the performance of such procedures or operations as are necessary and desirable in the exercise of the veterinarians' professional judgement. I also authorize the use of appropriate anesthetics and other medications, and I understand the risks involved.

_____ I understand that my pet will receive pre-anesthetic bloodwork to rule out pre-existing internal problems that could lead to serious anesthetic complications

_____ I understand that my pet will receive post-surgical pain control as deemed necessary by my veterinarian

In order to protect our patients from infectious diseases, we require that all animals entering the hospital are flea-free and show proof of current vaccinations through a licensed veterinarian for the following diseases: CANINE: Rabies, DHPP, Bordetella, and CIV. FELINE: Rabies, FVCRP (Distemper, Panleukopenia, Rhinotracheitis, Calici)

_____ I understand that my pet will be vaccinated as required if not proven to be current.

_____ I understand that my pet will be given flea treatment if fleas are found.

Microchipping: [ ] YES [ ] NO Nail Trim: [ ] YES [ ] NO
Ear Cleaning: [ ] YES [ ] NO Anal Gland Expression: [ ] YES [ ] NO

Sometimes during an anesthetic procedure, additional problems are detected and require further treatment. We will attempt to contact you before proceeding. However, if you cannot be reached, please initial below on how you would like us to proceed.

_____ I do NOT authorize any additional services without being contacted first.

_____ I authorize additional services but not to exceed [ ] $100 [ ] $200 [ ] $300

_____ I authorize any additional services that the doctor recommends during this procedure.

Signature of Owner or Responsible Agent _____ Date _____

Phone Number(s) where I may be reached today: _____