**Procedure Date: <appt-date>**

**<last-name>,** <first-name>

**<animal>** <breed> <color> <age> <sex>

I, the undersigned owner or designated agent, hereby authorize the staff of Shiloh Veterinary Hospital to perform the following procedure:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize anesthesia and understand that although anesthetic complications are rare, there is always the potential for complications, including death.

***Pain management:*** Our clinic strongly believes in compassionate, quality medical care for our patients. As a result, all surgical patients will receive pain management during surgery and recovery. Additional pain medication may be prescribed for use at home.

***Preanesthetic bloodwork:***

***□*** Labwork performed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_          Date performed \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***□*** Labwork needed morning of procedure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Additional procedures:*** By signing this form, I agree to have the following procedures performed ONLY if they are necessary. I realize that there is an additional fee for each of these procedures. Fees may vary.

\* ***Ear Cytology / Ear Cleaning*** may be performed if we see evidence of ear infections and/or mites.

***\*Flea treatments*** may be applied if fleas are noted to prevent an infestation of our hospital.

***\*Temporary (baby) teeth*** will be extracted if they are present in pets greater than 5-6 months of age.

***Microchipping:*** A microchip the size of a grain of rice can be injected under the skin to provide permanent identification for your pet if they ever become lost. This technology allows shelters and veterinarians to immediately contact the owner of a lost dog, even if they have lost their collar and ID tags.

***I would like my pet microchipped today yes\_\_\_\_\_\_\_ no\_\_\_\_\_\_\_ Already done\_\_\_\_\_\_\_***

***Elizabethan Collar:*** This is the “cone” that goes on your pet’s neck to help prevent licking/chewing of the surgery site. An e-collar is highly recommended to prevent post-operative damage to the surgical site. The owner is held financially responsible for all post-operative care needed as a result of not using an e-collar or other post-operative needs.

***□ Approve  □ Decline Client Initials\_\_\_\_\_\_\_\_\_***

***In the unlikely event that it becomes necessary to administer cardiopulmonary resuscitation (CPR) in an attempt to save my pet's life, my preference is:                     □ Yes, Please Administer CPR            □ No, Do Not Resuscitate (DNR)***

***I understand that there are no doctors or staff members scheduled to work at either Shiloh Veterinary Hospital from closing time (6:00 pm or 8:00 pm) until the following morning at 7:00 am.               \_\_\_\_\_\_ Client Initials***

Owner/Agent’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Order of call preference*** | ***Number*** | ***Home*** | ***Work*** | ***Cell*** | ***Between hrs. of….*** | ***Would you like to receive text notifications? \**** |
| ***Call FIRST:*** |  |  |  |  |  |  |
| ***Call 2nd:*** |  |  |  |  |  |  |
| ***Call 3rd:*** |  |  |  |  |  |  |

**\* Text messages are only monitored during surgery hours (Mon – Fri 7am – 3pm). Otherwise this is an unattended number.**