Shelbyville Road Veterinary Clinic

AUTHORIZATION & CONSENT FOR ANESTHESIA/SEDATION

It is important to understand all reasonable precautions will be taken to protect your pet and assure the best possible results. Please read this information sheet carefully and feel free to express any concerns you may have.

YOUR NAME: _____ **PETS NAME:** _____

Phone number(s) where you can be reached today:

_____ _____

•Procedure being performed today: _____

•Has your pet eaten today? YES ▢ NO ▢

•Has your pet been medicated today? YES ▢ NO ▢
If yes, what medications and time given: _____

•I understand that whenever anesthesia/sedation is given, some risk is involved. The amount of risk depends on many factors. We make every effort to minimize this risk; however, we cannot guarantee that a problem will not occur. Should **EMERGENCY PROCEDURES** (for example, CPR) be necessary in the attending veterinarian's professional judgment, **PLEASE CHECK ONLY ONE:**

▢ I authorize the Shelbyville Road Veterinary Clinic to proceed with all procedures and I agree to full financial responsibility for those procedures
▢ I prefer to be phoned prior to any additional procedures. However, if I cannot be reached, I authorize unforeseen procedures and assume financial responsibility for those procedures.
▢ If I cannot be reached, I do not authorize unforeseen emergency or life saving procedures.

The following questions **may or may not** pertain to your pet's procedure: **If your pet is here for a SURGICAL PROCEDURE, please answer the following:**

•If a mass is being removed today, we recommend submitting the mass to the lab for **histopathology**. Do you authorize this testing? YES ▢ NO ▢

•Does your pet need a **cone collar** to prevent licking of the incision? YES ▢ NO ▢

•Does your pet need **sedatives** to help with postoperative activity restriction? After surgery, 14 days of strict activity restriction will be required. YES ▢ NO ▢

If your pet is here for a TEETH CLEANING, please answer the following:

•Do you authorize **tooth extractions** if deemed necessary?

▢ YES
▢ Please call me first, but if I cannot be reached, proceed as medically advisable
▢ Do not perform any extractions, even if deemed necessary by a veterinary professional.

•Do you request **MICROCHIP** placement on your pet for permanent identification purposes?
YES ▢ NO ▢

•Do you need any refills of your pet's **heartworm, flea, or tick prevention**?
YES ▢ NO ▢

•I am the owner, responsible agent for, or authorized agent of this animal.
•I understand the nature of the procedure(s), that there are risks involved with any surgery or procedure, and that no guarantees are made as to the results or cure. I understand that sedation or general anesthesia may be necessary to relieve anxiety during procedures and/or to insure the safety of pets and employees.
•I authorize the veterinarians and staff of the Shelbyville Road Veterinary Clinic to perform all procedures that are documented above, including surgery, medical services, treatment, laboratory testing, radiographs, medications, and anesthetics.
•I understand that an attendant is not on hospital premises at night to monitor my pet
•The Shelbyville Road Veterinary Clinic will use all reasonable precautions against injury, escape, or death of my pet, but will not be held responsible in connection with or in any manner, as it is thoroughly understood that I assume all risks.
•Should it be necessary to transport my pet from the Shelbyville Road Veterinary Clinic to another veterinary medical facility for more extensive or intensive medical or surgical care, and/or diagnostics procedures, I hereby give my permission for transportation. I further specify and agree that the doctors and staff should not be held responsible in the event of disability and/or death associated with transportation.
•I AGREE TO PAY IN FULL FOR SERVICES PERFORMED INCLUDING THOSE DEEMED NECESSARY FOR MEDICAL OR SURGICAL COMPLICATIONS OR UNFORESEEN CIRCUMSTANCES. I WAIVE ALL RIGHT OF EXEMPTION AND AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING COURT COSTS AND ATTORNEY'S FEES.
•I have read and understood this authorization and consent.

_____
Owner or Responsible Party Date

Estimated cost of procedure _____

To be filled out morning of procedure _____ (Initial)