

Animal Medical of New City, PC
Procedure/Surgery Consent Form



Date: _____

Client's Name: _____

Pet's Name: _____

Phone # for Today: _____

Name of Contact: _____

Species: _____

PROCEDURES TO BE PERFORMED: _____

For the Safety of your pet:

- Yes No Was your pet fasted for 12 hours? _____
 Yes No Were any medications given this morning? _____
 Yes No Is your pet allergic to any drugs? (If yes, please list) _____

For your pet's protection, we require all patients be current on their vaccinations or titer checks. If we determine that your pet is due, may we:

- Vaccinate for the diseases recommended**
 Draw blood to check your pets titer

ELECTIVE PROCEDURES TO BE DONE AT THE SAME TIME

- | | | |
|--|---|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear Exam (ear smear, clean and flush as needed, pluck hair) | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heartworm Test | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Remove Warts and/or any Skin Growth (Location:) | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Express Anal Glands(infuse as needed) | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Dental Cleaning (Ultrasonic Scaling and Polishing) | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Permission to extract teeth if medically necessary | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Microchip identification | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Other (please describe) | _____ |

I authorize Animal Medical of New City, PC to perform such diagnostic, therapeutic, and surgical procedures as are in their opinion necessary and advisable for treatment and maintenance of my pet's health and well being including but not limited to the administration of anesthesia and the performance of services involving pathology and radiology. I expect all procedures to be done to the best of the abilities of the professional staff. I realize that no guarantee or warranty can ethically or professionally be made regarding the results or cure. I also authorize the doctor and his/her staff to provide veterinary services as requested or in emergency circumstances to follow through with such procedures as are necessary for the well being of my pet.

Client's Signature: _____

Admitted By: _____ Date: _____

Waiver of Blood Test(s) :

As owner or authorized agent of the owner of the animal named above, I have decided not to proceed with the blood tests recommended. The reasons for the blood tests have been fully explained to me as well as the risks inherent with not proceeding with the tests. In making this decision, I agree to absolve **Animal Medical of New City, PC** and the staff employed by this practice of any responsibility for the consequences of this decision. I have read and understand this waiver and I am over the age of eighteen.

Signature of Owner/Agent: _____

Date: _____

