 Animal Care Clinic Procedural Consent Form

 Dr. Robin O’Neill

 1315 6th Ave SE, Ste 3

 Aberdeen, SD 57401

Owner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone Number:\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pet’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pet’s Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I own, or have authorization over, the above-described animal.  I do hereby consent and authorize the Animal Care Clinic and its staff to administer and complete any/all tests and treatments agreed upon, that the doctors deem necessary for the health, safety and well-being of the above animal while it is under their care and supervision.

***\*\*\*For anesthetic procedures, please check any optional lab work you would like your pet to have\*\*\****

\_\_\_\_\_ Full bloodwork (CBC & Surgical Profile/lyte) prior to surgery \*$150.00

\_\_\_\_\_ Partial bloodwork (Surgical Profile/lyte only) prior to surgery \*$95.00

\_\_\_\_\_ Feline Leukemia/FIV test (felines only) prior to surgery \*$54.00

***OR***

\_\_\_\_\_**I decline any pre-anesthetic lab work being done on my pet**

The following surgical procedure and/or treatment will be performed on my pet:

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

I would like my pet to have an e-collar(cone) for the recovery phase (fee applicable) : ­ \_\_\_\_yes\_\_\_\_\_\_no (please initial one)

I request a Microchip for my animal \*$37.50  (email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_yes\_\_\_\_\_\_no (please initial one)

I agree to pain medication being prescribed, if deemed necessary. (fee applicable): \_\_\_\_\_yes\_\_\_\_\_\_no (please initial one)

***I understand that I am financially responsible for the above procedures and treatments***

***as discussed and agreed upon in the ESTIMATED charges of $\_\_\_\_\_\_\_\_\_\_\_\_(to be filled out by staff).***

 ***PAYMENT IS DUE AT THE TIME OF DISCHARGE (initial: \_\_\_\_\_\_\_\_\_)***

***Please choose which of the following payment options you will be using:***

**CASH\_\_\_\_\_             CHECK\_\_\_\_\_          CREDIT OR DEBIT CARD\_\_\_\_\_**

I understand that there are risks involved with treatment and surgical procedures such as my pet may injure itself, refuse food, vomit/have diarrhea, or die while in the hospital.  I will not hold the Animal Care Clinic and staff responsible and/or liable, in the absence of gross negligence.  I also understand that my pet may get ‘soiled’ while in the clinic for certain procedures despite the staff’s efforts to avoid this.

Signature of person authorized to consent for patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

(At discharge) I have received and reviewed the discharge instructions: \_\_\_\_\_\_\_\_\_