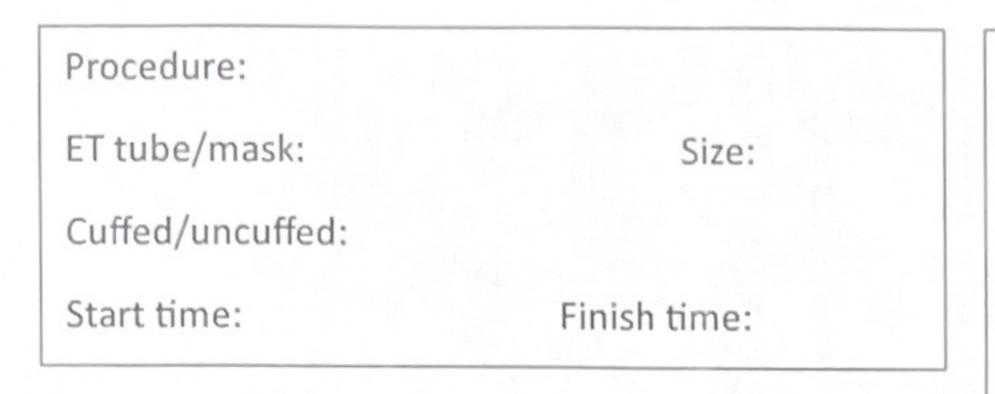


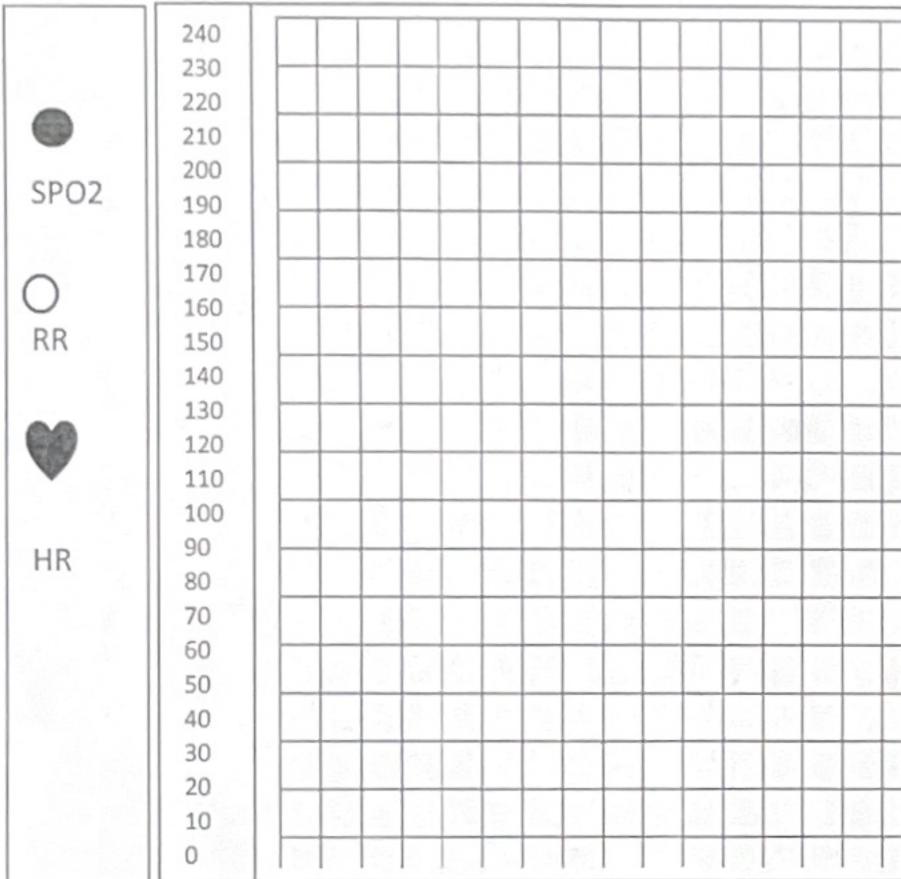
## Procedural Consent Form

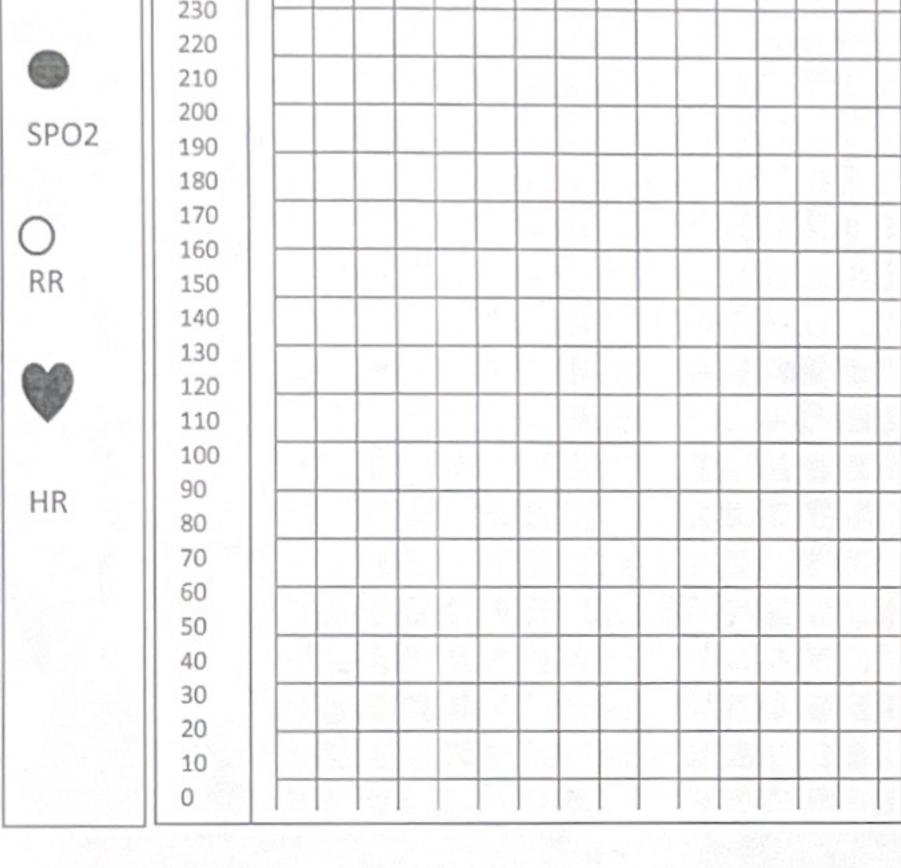
Dr. Robin O'Neill 1315 6th Ave SE, Ste 3 Aberdeen, SD 57401

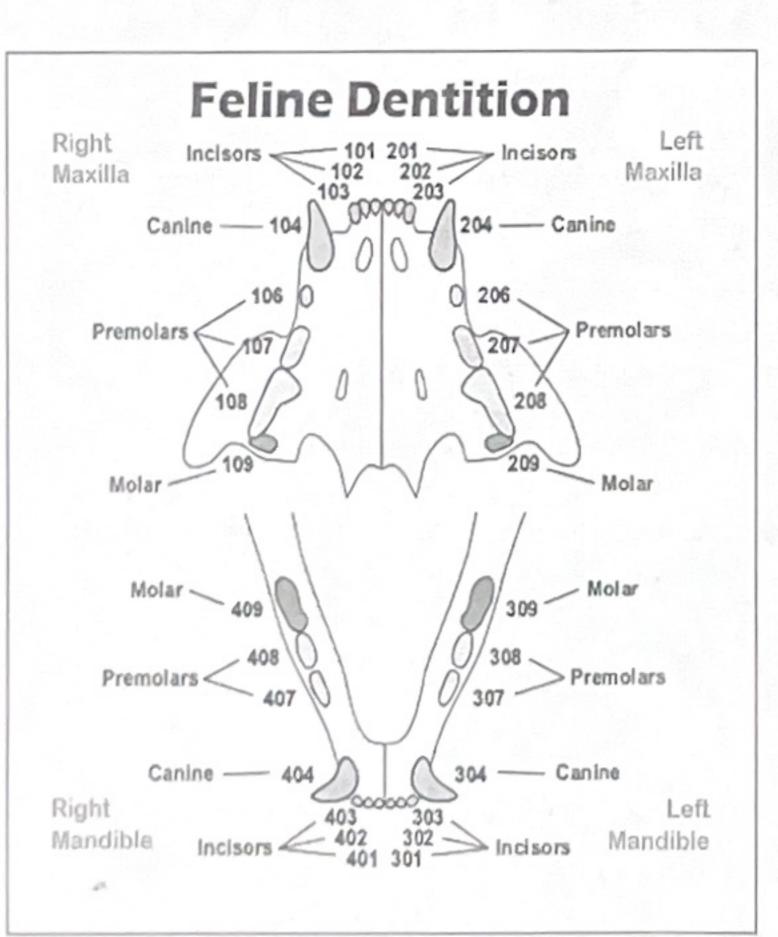
(At discharge)

Owner's Name			Phone	dmnn	er		
Address:							
Pet's Name:			Pet's Age: _				
the Animal Care	Clinic and its staff n necessary for the	ation over, the above-or to administer and come health, safety and we	plete any/all	tests a	nd treatm	ients a	greed upon, that
***For anesthet	ic procedures, ple	ease check any option	nal lab work	you w	ould like	your	pet to have***
	Partial	odwork (CBC & Surgical bloodwork (Surgical Profi eukemia/FIV test (feline: OR	ile/lyte/SDMA	only) pr	ior to surg	ery *\$1	
	l declin	e any pre-anesthetic lal	b work being	done o	n my pet		
The following surg	gical procedure and/o	r treatment will be perfor	med on my pe	et:			
	*please pic		y phase (varyin				(please initial one)
I request a Microch	ip for my animal *\$37.	50 (email:		) _	yes	no	(please initial one)
I agree to pain med	ication being prescribe	d, if deemed necessary. (fe	ee applicable)	-	yes	no	(please initial one)
as dis	cussed and agreed up	m financially responsible to oon in the ESTIMATED cha THE TIME OF DISCHARG	arges of \$		_(to be fill	ed out l	s by staff).
	Please choose wh	nich of the following p	payment opt	tions y	ou will b	e usin	g:
	CASH	CHECK	CREDIT OR	DEBIT	CARD_		
food, vomit/have of liable, in the abser	diarrhea, or die while	ed with treatment and sur in the hospital. I will not ce. I also understand the avoid this.	hold the Anim	al Care	Clinic and	staff re	esponsible and/or
Signature of pe	erson authorized t	to consent for patient	::				Date:
*********			*******			****	
(At discharge)	I have received and	d reviewed the dischar	ge instructio	ns:			









X-Extracted M-Missing #-Fractured



Medication	Dose	Route	Time
			7

Breathing	Patient position:		
System:	Patient warming:		

