

## Surgery/Hospitalization Consent Form

Crater Road Veterinary Hospital

464 S. Crater Rd. Petersburg, VA. 23803

Office: 804-733-8202 Fax: 804-733-6522

**Please fill out all highlighted areas (front and back)**

Owner's name: \_\_\_\_\_

Account # \_\_\_\_\_

Pet's name: \_\_\_\_\_

Date: \_\_\_\_\_

### Please answer the following below:

Did your pet eat this morning? \_\_\_\_\_

Has your pet ever had a seizure? \_\_\_\_\_

Has your pet had any reactions to any medications? \_\_\_\_\_

Is your pet currently on **ANY** medications? \_\_\_\_\_

Has your pet had any reactions to vaccines? \_\_\_\_\_

Has your pet had any reactions to anesthetics? \_\_\_\_\_

**Procedure to be done today:** \_\_\_\_\_

In addition to today's procedure, patients occasionally require further treatment based upon the veterinarian's findings and/or patient response to the procedure. Crater Road Veterinary Hospital will do what is medically necessary and in the best interest of your pet.

**Pre-anesthetic blood work and IV catheter/fluids:** We strongly recommend pre-anesthetic bloodwork be performed prior to anesthesia for patients under 6 years old. This may help us avoid possible complications from the procedure to be performed. **Please note** that pre-anesthetic blood work and IV catheter/fluids will be required for pets 6 years and older.

- ❖ **OPTIONAL** Pre-anesthetic bloodwork (under 6 years old) : Approve \_\_\_\_\_ Decline \_\_\_\_\_ Initial one
- ❖ **OPTIONAL** IV Catheter (under 6 years old): Approve \_\_\_\_\_ Decline \_\_\_\_\_ Initial one
- ❖ Pre-anesthetic blood work & IV catheter (6 years and older) **REQUIRED:** \_\_\_\_\_ Please Initial

### Add On's (please circle)

Nail trim

Anal gland

Microchip

Ear cleaning

**Please continue to back**

**In the event of a life threatening situation, would you like us to:**  
**CPR/RESUSCITATE (Please Initial one)**

**Approve:** \_\_\_\_\_ **Decline:** \_\_\_\_\_

- I understand that during the performance of the foregoing procedure, unforeseen conditions may be revealed that necessitates extension of the foregoing procedures or are different than those set forth above. Therefore, I hereby consent and authorize the performance of such procedures as are necessary and desirable in the exercise of the veterinarian's professional judgment. **Initial:** \_\_\_\_\_
- I will be available by phone to be kept informed. I also authorize the use of appropriate anesthetics and/or other medications. I understand that the hospital support personnel will be employed as deemed necessary by the veterinarian. **Initial:** \_\_\_\_\_
- I have been advised as to the nature of the procedures and risks involved. I realize the results cannot be guaranteed. **Initial:** \_\_\_\_\_

I have read and understand this authorization and consent. I am also aware that I am responsible for **FULL** payment when my pet is released from the care of Crater Road Veterinary Hospital. **There is a 50% deposit required on surgeries exceeding \$500.00 at check in and remainder is due at pickup.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Number: \_\_\_\_\_

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**Dental Release (for scheduled dental procedures only)**

Today your pet is having a dental cleaning under anesthesia. Your pet's mouth will be thoroughly examined for dental disease. Teeth will **ONLY** be removed if the doctor feels it is medically necessary. Your pet may also be sent home with antibiotics and or pain medications, especially if the gums are inflamed or the mouth is diseased.

If your pet requires medically necessary extractions, would you prefer to be called first? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Please note:** If we are unable to reach you, we will do what is medically necessary and what's in the best interest of your pet.

I authorize Crater Road Veterinary Hospital to perform a dental cleaning with possible extractions. I agree that the bill is to be paid in full upon my pet's release.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_