Desert View Animal Hospital
940 Elk Street
Rock Springs, WY 82901
(307) 362-3184

Authorization for Elective Anesthetic Procedure(s) and/or Surgery

Client's Name _____ Pet's Name _____

Species _____ Age _____ Date _____

Anesthetic and surgical procedure(s) to be performed: _____

The most serious or common complications include: Excessive Bleeding, Infection, Anesthetic complications up to and including death

Please list any medications or supplements your animal may have had within the last 7 days and when the last dose was given: _____

_____

_____ I, the undersigned owner or authorized agent of the owner of the pet identified above, certify that I am over eighteen years of age, and hereby authorize Desert View Animal Hospital to perform the above procedure(s) and additional diagnostic, treatments, or surgical procedures as deemed necessary for medical or surgical complications or otherwise unforeseen circumstances. I also authorize the use of appropriate anesthetics and other medications.
_____ I understand that some risks always exist with anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before the procedure(s) is/are initiated. The nature of the procedure(s) has been explained to me and no guarantee has been made as to the results of the procedure. I understand that there may be risks involved in these procedures and with any anesthesia or pain medication. My signature on this form indicates that any questions I have regarding the following issues have been answered to my satisfaction:

- The reasonable medical and/or surgical treatment options for my pet
- Sufficient details of the procedures to understand what will be performed
- How fully my pet will recover and how long it will take
- The most common and serious complications
- The length and type of follow-up care and home restraint required
- The estimate of the fees for all services

_____ While I accept that all procedures will be performed to the best of the abilities of the staff at this hospital, I understand that veterinary medicine is not an exact science and that no guarantee or warranty has been made regarding the results that may be achieved. **I will not hold Desert View Animal Hospital, the Doctors, or the staff liable for any complications.**

_____ Should my animal unexpectedly require CPR or other life-saving emergency care and the hospital staff is unable to reach me, the staff: (initial one)
_____ HAS
_____ DOES NOT HAVE
my permission to provide such treatment and I agree to pay for such services at the time my bill is due.
_____ I acknowledge that changes in my pet's condition or discovery of other findings during surgery may necessitate a change in or an extension of the original estimate and if this occurs, a staff member will attempt to contact me to update this figure.
_____ I understand that hospital support staff will be used as deemed necessary by the veterinarian. If my pet is hospitalized beyond the first day at this facility, I understand that Desert View Animal Hospital is not staffed twenty-four (24) hours a day and that veterinary care during night time hours and/or weekends is provided at the discretion of the attending veterinarian. Continuous presence of personnel may not be provided during these hours.
_____ Though most patients go home the same day or the next day, I understand it is my responsibility to call the hospital at least every twenty-four hours to inquire as to the medical status of my pet and the fees incurred for medical services up to that day should my animal have to stay longer and the attending doctor is unable to reach me.

	Additional Procedures	Accept	Decline
Pre-anesthetic Lab Work **$ 56.03** (Include Blood Draw Fee)	Lab tests recommended better evaluate your pet internally and establish a baseline for future reference ☐ Packed Cell Volume/Pre-anesthetic Screen* ***Required** for dogs over 9 years, giant dog breeds over 5 years and cats over 12 years ☐ Complete Blood Count ☐ Other_____	[ ] **Required** [ ]	[ ]
Intravenous Catheter and Fluids **$ 35.61**	**Required** for spays over 55 pounds body weight, dogs over 9 years, giant dog breeds over 5 years and cats over 12 years Required for multiple, extended and advanced procedures	[ ] **Required** [ ]	[ ]
ECG Screen **$ 32.19**	Assess cardiac rhythm for irregularities that may complicate anesthesia May be required at the Doctor's discretion	[ ]	[ ]
Go Home Pain Medication **$ 10.00 - $ 74.01**	All animals receive pain medication during the procedure(s). Spays and declaws will go home with pain medication. Other procedures go home with pain medication at the doctor's discretion. I would like my animal to go home with additional pain medication	[ ]	[ ]
Microchip Placement **$ 35.00**	This will help to identify your pet in case it becomes lost or stolen	[ ]	[ ]

_____ This document serves as confirmation of receipt of an estimate for the medical care plan that will be carried out for and on my pet in the range of $_____to $_____. My signature below signifies that I understand and accept responsibility for the payment of these estimated fees as they are performed by this facility. All elective procedures must be paid for at the time of service. Even though these procedures may be recommended for your animal, they are not required for the immediate improvement of the animal's health or well-being and are not considered vital to the short-term health of the animal. I am encouraged to discuss all fees attendant to such care before services are rendered and during this pet's ongoing medical treatment. I agree to assume financial responsibility for the balance of all services rendered on a cash, credit card, Care Credit or check basis at the time the pet is discharged from the hospital. *Please note: The high end of the estimate includes the additional elective procedures listed above.*

_____ Payment is expected when services are rendered. **Should I fail to pay at any time any portion of the bill for my pet's care, I agree to pay the costs of all delinquency charges, collection charges and reasonable attorneys' fees.** I have read and understand this authorization of consent. **I agree to pay the balance of the above estimated fees at the time of my pet's discharge.**

The final balance will be paid by: (please initial one)

_____ Cash
_____ Check
_____ Credit Card (Visa, Master Card, Discover)
_____ Care Credit – Must be approved or have a valid account at the time of admittance

_____ I further agree that either I, or an authorized agent of mine, will pick up this pet and pay for all accrued charges within five days after receiving written or oral notification that this animal is ready to be released from the hospital. Such notice will be given at the address maintained on the hospital's patient/client record. I agree that if I fail to comply with this policy, this practice may handle this abandonment in the best interests of the pet and the hospital and I will still be responsible for all fees incurred.

I have read and understand this authorization of consent and give my consent to proceed. I hereby consent and authorize the above procedure(s).

(_____) _____-_____ (_____) _____-_____

Phone number(s) for today

_____ _____

Signature of Owner or Authorized Agent Date