SURGICAL CONSENT

P (803) 648-4245 F (803) 648-9136 arkanimal2680@gmail.com

We recommend any pet undergoing general anesthesia to have a comprehensive blood screening performed in addition to his or her pre-surgical physical examination. In many cases, a pet may have underlying pre-existing conditions not apparent just upon examination that could affect their anesthetic experience and surgical outcome, and this important testing allows us to form a unique pre-anesthetic profile in order to tailor anesthesia to each patient's individual needs. Would you like your pet to have this valuable screening performed?

☐ Yes, I would like my pet to have pre-anesthetic blood screening performed.

☐ No, I decline having pre-anesthetic blood screening performed for my pet

If you would like us to perform any additional services for your pet during his or her stay with us, please let us know below: (Additional services will incur additional charges accordingly.)

_____ Nail Trim (Clip ☐ Dremel ☐)

_____ Anal Gland Expression

_____ Microchip Placement

_____ Ear Cleaning

_____ Annual Physical Exam

_____ Vaccines _____

_____ Other _____

_____

AUTHORIZATION

I, the undersigned owner or authorized agent of the animal named _____, hereby authorize The Ark Animal Hospital, P.C., Dr. Jay H. Jones, and his associates or assistants to administer such treatments and to perform such procedures as are considered therapeutically and/or diagnostically necessary for the care of my animal, including the administration of anesthesia. In the event that emergency treatment is required and I cannot be reached, I authorize Dr. Jones and his associates or assistants to perform such medical and surgical treatment as is necessary to preserve the life of the patient until I can be contacted for further authorization. I understand that no guarantee of successful treatment is made. I accept financial responsibility for the treatment of the above-named patient and understand that payment in full is due upon release of this animal from the hospital or when service is otherwise terminated. I certify that I have read and fully understand this authorization for medical and/or surgical treatment, the reason why such medical and/or surgical treatment is considered necessary, as well as its advantages and possible complications, if any. I hereby release Dr. Jones and his associates or assistants from any and all claims for negligence, arising out of or connected with the performance of his/her treatment.

_____ _____

Owner or Agent's Signature Date

_____ _____

Address Phone #