Family Pet Clinic of NRH.

6724 Mid-Cities Blvd.
North Richland Hills, TX 76180
Main: (817) 788-2525
Fax: (817) 788-5575

Anesthesia - Surgical Consent Form

Staff Initials _____

WL _____WB_____

ID:	<number>	Date:	<date>	Provider:
Client Name:	**<last-name>, <first-name>** (<spouse>)	Patient:	**<animal>**	**<appt-doctorname>**
Address:	<address> <city>, <st> <zip>	Species: Breed:	**<species>** <breed>	
Phone:	<area>-<phone> <cell-phone>	Color: Sex:	<color> <sex-name>	
Email:	<e-mail>	DOB:	<birthday> (<age-name>)	
Allergies:	**<allergy>**	Weight:	<weight>	

<animal-pic>

Our greatest concern during anesthesia and surgery will be the welfare of your pet. Before putting your pet under anesthesia, we will perform a pre-surgical physical examination. *However*, many conditions, including disorders of the heart, liver, kidneys or blood may not be detected unless blood and heart testing are performed. To avoid potential problems and to further protect your pet's health and safety, we strongly recommend blood screening prior to any anesthetic procedure. ***Hospital policy requires analgesia (pain medication) be provided to all pets receiving surgery at owner's expense. IV catheterization and fluids are also required for all pets (except in cases of feline neuters unless specifically requested by owner). The pet must also be current on vaccines and free from external parasites or the hospital will provide such services at owner's expense. Surgery will not be scheduled and/or begun without owner's consent below of these policies.*** Your pet will be closely monitored while under anesthesia, but even with close monitoring, anesthesia carries risk of complications, including death.

Owner Acknowledgements
(**All 4 Statements** Must Be Acknowledged To Proceed)

_____ I understand that my pet must be current of required vaccines and free from external parasites to be admitted into the hospital or the hospital will provide the necessary services at my expense.

_____ I understand that FPC will provide pre-/peri-operative and post-operative analgesia to my pet at my expense.

_____ I understand that FPC will provide pre-/peri-operative IV catheterization and fluids to my pet at my expense.

_____ I have received a written treatment plan for the scheduled surgery/procedure. I understand that the treatment plan provides only an estimate to the services and charges. Actual services and charges may vary for which I agree to pay in advance or at time of discharge.

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Reason for Visit:_____

******Owner Elections******
(Select **Only 1 Election** To Direct Services Outside of Provided Treatment Estimate)

_____ I authorize FPC to perform ***All Services*** recommended by the veterinarian and agree to cover the cost of such services ***without being contacted for approval after drop-off admittance.***

_____ I authorize FPC to perform ***Only The Following*** electable services recommended by the veterinarian and agree to pay for selected services ***without being contacted for approval after drop-off admittance***:

[ ] Pre-Anesthetic Diagnostics ($105-206)
[ ] IV Catheterization Option - Feline Ntr Only ($38)
[ ] Dental Xrays / Teeth Extraction ($14-Varies)
[ ] _____

[ ] Ear Cleaning ($15-34)
[ ] Umbilical Hernia Repair ($40)
[ ] Advanced Dental Services (Varies)
[ ] _____

_____ I authorize FPC to perform ***Up To $_____*** of electable services recommended by veterinarian ***without being contacted for approval after drop-off admittance*** and am responsible for billed amount.

_____ I wish to ***Be Contacted Before*** any additional veterinarian recommended services are provided. **Note: During anesthesia, immediacy is necessary. Please ensure that we are able to contact you at the correct phone number listed on this document and you are available when called to provide us your decision. If we are unable to reach you within a time deemed safe for your pet, we will not proceed with the additional recommended services and you can elect to have these performed at a later date.

✓ **Verify Phone** <area>-<phone> or Preferred_____
<cell-phone>

Our staff will contact you when your pet is in recovery or if there are any problems/questions. Thank you for choosing Family Pet Clinic for the treatment of your pet. Rest assured that we will provide the comfort and safety you expect and per your release. Please see one of our staff members and review the explanation of services if you have any questions.

Owner Responsibility

I, being responsible for the above named pet(s), have the authority to grant Family Pet Clinic my consent to receive, prescribe for, treat, and perform surgery on said pet(s). I also consent to the administration of anesthesia as needed. I acknowledge that no assurance or guarantee has been made of the results of anesthesia, treatment, and/or surgery, and possibilities of complications exist with any anesthesia, treatment, and/or surgery. All charges, including boarding costs, shall be paid in full when pet is released from the hospital/clinic unless previously arranged with the hospital. If contact is not made by phone or in writing within 10 days of the specified date of release/pick up, the pet will be considered abandoned. It is understood that abandonment does not relieve me from paying any and all costs of said services and use of this hospital/clinic, including cost of boarding. There will be a fee for checks returned to us for any reason.

Signature of Owner or Authorized Representative

_____ Date: _____

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For Internal Use Only

<animal>
<last-name>
<species> <breed> <color> <sex-name> <birthday>(<age-name>)

Patient Alert: <animal-alert>
Appointment Notes: **<appt-notes>**
Check In Time: <time>
Reminders <reminders>

<animal-pic>

Check In Weight_____ Check In Temp_____

Check In HR_____ Check In RR_____

Check In CRT_____ Check In MM_____

Reason for Visit:

Additional Services:

Special Instructions:

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Place Pet's Label here						
OR						
Client Name						
Pet Name						
Age						
Phone Number						
Procedure:						
Veterinarian:						
Assistant:						
A. Preoperative Exam	Wt	Temp	HR	Resp	CRT	MM
B. ASA Physical Status	I	II	III	IV	V	E
C. Preanesthetics	Amount	Route	Time/Initials			
Atropine	ml	SQ IM IV				
Rompun	ml	SQ IM IV				
Torbugesic	ml	SQ IM IV				
Dexdomitor	ml	SQ IM IV				
Ketamine	ml	SQ IM IV				
Rimadyl	ml	SQ IV				
Metacam	ml	SQ				
D. Induction Agent	Amount	Route	Time/Initials			
Propofol	ml	IV				
Isoflurane	%	Mask/Chamber				
Oxygen	L/min					
Sevoflurane	%	Mask/Chamber				
E. Maintenance	Amount	Route				
Isoflurane	%	Mask ETT				
Oxygen	L/min	Mask ETT				
Sevoflurane	%	Mask ETT				
F. Ancillary Items	MC	HW Test	Fecal	Rabies	DHPP-1	Lepto
ETT	Size	mm	FVRCP	FeLV	DHPP-3	Borde
Breathing System	Regular	Non-Rebreather				
Catheter	**Location**	LF	RF	LR	RR	
	Gauge	24 ga	22 ga	20 ga		
Fluids	**Type**	LRS	Norm R	Plasmalyte	0.9% NaCl	
	Rate	ml/hr				
	Total Amnt	mls				