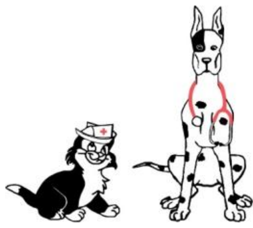

ANIMAL MEDICAL CLINIC
200 Sheldon Road
Manchester, CT 06042
www.AnimalMedicalClinicCT.com
(860) 646-1110

SURGICAL/TREATMENT CONSENT

ID: ________________

OWNER'S NAME: ____ EMAIL: ________________________________

ADDRESS: ____________________________________ CITY:___________________ STATE:_______ ZIP CODE:_________

HOME PHONE: (___)________________ CELL PHONE: (___) _______________ WORK PHONE: (___)________________

PET'S NAME: ___________________ SEX: ______ SPECIES: _________ BREED: ___________ AGE: _____ WEIGHT: ______

Surgical Procedures: (X all that apply)

____Spay (< 1 yr.) (mature >1 yr) (in heat) ____Dental ____Dental Extractions (if any) ____Ear Crop
____Neuter (< 1yr.) (mature >1 yr) (Cryptorchid) ____Mass Removal ____Laser Declaw (Feline) ____Dew Claw and/or Tail Dock
____Exploratory ____Cystotomy ____Gastropexy ____Wound/Laceration/Abscess
____Exam/Treatment w/Sedation/Tranquilization ____Laser Nail Trim ____Other Surgical Procedure ____________________

Reproduction: ____Vaginal AI ____Transcervical Insemination ____Surgical Implant ____Progesterone(s) ____Board for breeding

Treatment: (X all that apply)

____Walk-In/Drop-Off Exam Fee ____Blood Work/Laboratory ____Scheduled Drop Off/Exam
____Vaccines ____Anal Gland Expression ____Nail Trim (Regular) ____Microchip Implant
____BG Curve ____4DX/Accuplex ____FELV/FIV Testing ____Boarding ____Day Hospitalization
____X-rays ____OFA(Hip/Elbow/Thyroid) ____PennHIP ____Hospitalization (Medical) ____Hospitalization (ICU)
____IV Fluids ____Pain Medication/Inj. ____Other Treatment (describe)________________________________
____

All reasonable precautions will be taken against injury, escape, or death of hospitalized patients. **The Animal Medical Clinic, its staff and/or veterinarians, will not be held liable or responsible in any manner in connection there with as it is thoroughly understood that I assume all risks.** I also understand that the Animal Medical Clinic is not staffed 24 hours a day and after-hours treatment of patients is at the discretion of the veterinarian.

All Walk-in/Drop Off (Admissions) will be required to leave a minimum $250.00 deposit on non-routine/emergency procedures. All remaining charges/balances shall be paid in full upon discharge from the hospital. WE DO NOT ACCEPT CHECKS. We do not bill.

~WE ACCEPT CASH, DEBIT, CREDIT CARDS, VISA, MASTER CARD, AMERICAN EXPRESS, DISCOVER AND CARE CREDIT~

CONSENT FOR SURGERY/TREATMENT: I, being responsible for the above animal/animals, have the authority to grant the ANIMAL MEDICAL CLINIC my consent to receive, prescribe for, treat, and/or operate upon my pet. I understand that any quoted fees are "estimates" only and individual treatments and/or surgical procedures may require more time and/or surgical materials at additional costs. I understand and agree to the following surgery and or treatment plans and agree to pay all costs incurred for any and all professional services. I further understand that if further treatment is required, I will be contacted for verbal authorization of treatment and additional cost prior to administration of further treatment.

AFTER READING THE ABOVE, I HAVE SIGNED IN AGREEMENT BELOW

Owner or responsible party (over age 18): _______________________ Print Name: ______________________ Date: ____________

The Veterinarians at the Animal Medical Clinic recommend pre-anesthetic blood work for all patients undergoing anesthesia/ tranquilization. Pre-anesthetic blood work is required for all animals over 7 years of age. The blood work will assess for any contraindication to performing the procedure at this time; i.e. liver, kidney or other underlying dysfunction. The approximate cost for blood work can range from $50-$150. If blood work has been obtained within 30 days prior to the procedure and was within normal limits, the veterinarian may agree to waive pre-anesthetic blood work.

I ACCEPT PREANESTHETIC BLOODWORK (Please Sign) ____

I DECLINE PREANESTHETIC BLOODWORK (Please Sign) ____

BLOOD HAS BEEN PREVIOUSLY OBTAINED WITHIN THE LAST 30 DAYS: _________ Date Obtained: ________ Where: _________

PATIENT MEDICAL HISTORY
(Please fill out both sides)

DATE: _______________ *Patient ID:* ________________________

OWNER NAME: _________________________ **PET'S NAME:** _________________ **AGE:** __________ __ **WEIGHT**___________

(Please Fill out only if you have had a Change of Address or Contact Information since last visit):
NEW ADDRESS: _____________________________________Apt/Unit#_________CITY_____________________STATE_______
HOME PHONE: (__)_______________ CELL PHONE: (__) ____________________WORK PHONE: (___)________________________
EMAIL:_________________________

Describe Reason for Today's Visit in as Much Detail as Possible:

____
____
____
____
____
____

Diet Information:

Brand: _________________ How Much:_________ How Often:_________ When Did Patient Last Eat? _______________________

Nutritional Supplements (List) ________________________ Treats: ____

Medication Information: (Please List):
Medication _______________ Strength___________ How Often ___________________ Last Dose Given? (Date/time)______________
Medication _______________ Strength___________ How Often ___________________ Last Dose Given? (Date/time)______________
Medication _______________ Strength___________ How Often ___________________ Last Dose Given? (Date/time)______________
Medication _______________ Strength___________ How Often ___________________ Last Dose Given? (Date/time)______________
Medication _______________ Strength___________ How Often ___________________ Last Dose Given? (Date/time)______________

Does your Pet have any Allergies (please describe):____
____
____

Is your Pet on Heartworm Prevention? Yes No **Year Round?** Yes No **Brand**?______________________________
Do You Need Any Today? Yes No

Is your Pet on Flea/Tick Prevention? Yes No **Year Round?** Yes No **Brand**?______________________________
Do You Need Any Today? Yes No

DOGS: Does your dog do any of the following:
_____Hunt ____Run/Hike in Woods _____Exposed to Livestock _____Board/Groom regularly or periodically
_____ Come in contact with other Dogs

CATS: Is your cat ______ Indoor? ______ Outdoor? ______ Both?

Has your cat EVER been tested for Leukemia or Feline Aids? Yes No **(if yes, When?)**_________________

Over ….

Patient Medical History -page 2-

DATE: ______________ *Patient ID:* ______________________

OWNER NAME: __________________________ **PET'S NAME:** ________________ **AGE:** ___________ **WEIGHT**__________

Has your pet exhibited any of the following symptoms?

____Weight Loss?	____Weight Gain	How long? __________________
____Appetite Decrease?	____ Appetite Increase?	How Long? __________________
____Increased Thirst?	____ Decreased Water Intake?	How Long? __________________
____Vomiting? How Often? _______	____ Diarrhea? Consistency?______	How Often?_______
____Constipation /Difficulty having BM?	____ Incontinence of Urine (dribbling)?	_____ Incontinent of Feces?
____Bad Breath?	____ Drooling?	____Difficulty chewing/eating?
____Coughing?	____Sneezing?	How Long? __________________
____Wheezing?	____ Gagging/Choking?	How Long? __________________
____Runny Nose?	____ Eye Discharge?	How Long? __________________
____Difficulty getting up/Stiff?	____ Difficulty climbing stairs?	How Long? _________________
____ Incoordination?	____Lameness/Limping?	Describe: ____________________
____Decreased Activity?	____Listlessness?	Describe: ____________________
____Weakness?	____Muscle Tremors?	Describe: ____________________
____Shaking (body)?	____Seizures?	Describe: ____________________
____ Head Tilt?	_____Shaking head?	Describe:_____________________
____Behavior Change?	____Unusual Discharge?	Describe: _____________________
____Odor?	____Scratching/Licking?	Describe: _____________________
____ Poor Coat?	____ Hair loss?	Describe: _____________________
____Skin Sores ?	____Lumps or Bumps?	Location(s) ____________________

Please describe any other problems or concerns: ____
____

I hereby authorize ANIMAL MEDICAL CLINIC, it's doctors and staff, to perform professional services as are in their opinion necessary and advisable for treatment and management of my pet's health, medical problems and acknowledge authorization of all treatments (as deemed necessary by the veterinarian) to be performed as outlined and initialed by me on the Surgical/Treatment Consent Form. I further agree that an initial treatment plan has been explained and that further recommendations may be made pending diagnostic results which may incur further costs, for which I will be informed prior to undertaking of further treatment plans not already agreed upon. I understand that with either written and/or verbal authorization by telephone, that I am responsible for all charges incurred and that all services are to be paid at the time they are delivered or at discharge of my pet. I understand that a 50% deposit may be required upon admission with the remaining balance due upon discharge.

AUTHORIZATION FOR PROFESSIONAL SERVICES (Must be over age 18):

Signed: _____________________________________ Prepared By:____

Print Name:__________________________________ Date: _____________ Time: ___________

NUMBER I CAN BE REACHED TODAY: (1)______________________________(2)_________________________________