# CLARKE COUNTY ANIMAL HOSPITAL
# DR. ED SELLERS

## AUTHORIZATION & CONSENT FOR HOSPITALIZATION /SURGERY

Owner's Name _____ Pet's Name_____

I am the owner or agent of the above described animal and have the authority to execute this consent and authorization of the following procedure/care:

_____

I understand that during the performance of procedure for the above situation(s), unforeseen conditions may be revealed that necessitates an extension of the foregoing procedures, or even different procedures, than those set forth previously. I hereby consent and authorize the performance of such procedures as necessary and desirable in the exercise of the veterinarian's professional judgment. I have been advised of the nature of the services and procedures as well as the risks involved and I also realize that results cannot be guaranteed.

I additionally authorize the use of appropriate anesthetics, pathologist examination of excised tissue(s) deemed appropriate by the veterinarian and the administration of other medications, and understand that hospital staff will be utilized as deemed necessary by the veterinarian. I have read and understand this authorization and consent.

_____ _____

(Signature of Owner or Agent) (Date)

***Below is a list of optional procedures and test that you may like to consider having done at this time. Doing these now will eliminate additional anesthetic risks in the future and also save you the cost of additional anesthetic:**

| | | |
|---|---|---|
| _____Dental | _____Anal Gland Flush | _____Hernia Repair |
| _____Urinalysis | _____Tumor/Growth Removal | _____Declaw |
| _____Ear Flush | _____Electrocardiogram | |
| _____Radiology (Chest) | _____Radiology (Abdomen) | |

The above indicated procedures and tests will be conducted at your expense, if deemed necessary, unless you waive this level of care for your pet. Please place a mark by the procedure/procedures that you wish to have completed today. If you do not wish any procedures or tests to be preformed and want to waive your animal's rights to these needed procedures and tests, please indicate by signing below:

**Authorized To Waive Care Agent: _____**

# SURGERY & ANESTHESIA

Physical Exam Checklist:

| | | | |
|---|---|---|---|
| General Appearance<br>( )Norm ( )Abnorm | Integumentary<br>( )Norm ( )Abnorm | Musculoskeletal<br>( )Norm ( )Abnorm | Circulatory<br>( )Norm ( )Abnorm |
| Respiratory<br>( ) Norm ( ) Abnorm | Digestive<br>( )Norm ( ) Abnorm | Genitourinary<br>( )Norm ( )Abnorm | Eye |
| Ears<br>( )Norm ( )Abnorm | Neural System<br>( )Norm ( )Abnorm | Lymph Nodes<br>( )Norm ( )Abnorm | Mucous Membranes<br>( )Norm ( )Abnorm |

T_____P_____R_____WT._____DIET:_____

**Presurgical Lab Results:**

**Blood:**

PCV___ WBC___ RBC___ NEU___ SEG___ EOS___ LYM___ MON___ BAS___ IMM___

**Chemistry:**

BUN___ CLU___ CRE___ AML___ GOT___ ALP___ ALT___ CA___ TP___ ALB___

**Urine:**

CLR___ PH___ SG___ KET___ GLU___ PR___ URB___ BLR___ BIL___ SED___

Rads: Yes No

Ecg: Yes No

Surgical Procedure:

1. _____
2. _____
3. _____

Describe:

Type: Major____ Minor ____ Elective____ Date of Surgery_____

Premedication

| | |
|---|---|
| Atropine | ___ml/mg IM/IV |
| Acepromazine | ____ml/mg IM/IV |
| _____ | ____ml/mg IM/IV |

Induction

| | |
|---|---|
| Biotal___% | ____ml |
| Telazol | ____ml |
| Ketamine | ____ml |
| Valium | ____ml |
| _____ | ____ml |

Maintenance

| | |
|---|---|
| Local Anesthesia | Y N |
| Methoxyflourane/O2 | ____min |
| Halothane/O2 | ____min |
| Isoflourane/O2 | ____min |
| Nitrous Oxide | Y N |

I/V Therapy

___Whole Blood
___Lactated Ringers
___Isotonic Saline
___5% Dextrose
___Mannitol
___Others

Drugs Given During Anes.

___Cardiac Stimulants
___Analgesics
___NA Bicarbonate
___Other