ARROWHEAD
VETERINARY HOSPITAL INC.

1620 L Road, Fruita, CO 81521 T: (970) 858-8881 F: (970) 858-9367 www.arrowheadvethospital.com

MEDICAL, ANESTHETIC, AND PRE-SURGICAL CONSENT FORM

Client Name: _____ **Date:** _____
Last **First**

Address: _____

Home Phone (___) _____**Cell Phone (___)** _____**Alternate Phone (___)** _____

Patient Name: _____**Procedure:** _____

Species: _____ **Breed:** _____ **Age:** _____ **Sex:** _____ **Color:** _____

Pre-Anesthetic Blood Work Release

Your pet is scheduled for an anesthetic procedure. We recommend a comprehensive blood analysis to determine your pet's anesthetic risk criteria. In addition, these results may serve as a baseline for future comparison and evaluation.

☐ $60.00 / CBC + Limited Chemistry (basic kidney, liver and organ function, assists in detection of inflammation, infection, anemia, dehydration etc.)

☐ $102.00 / CBC + Extensive Comprehensive Chemistry (kidney function, liver function, electrolytes, assists in detection of inflammation, infection, anemia, dehydration, etc.)

☐ I decline the recommended pre-anesthetic blood work at this time and request that you proceed with the anesthesia, although anesthesia risk for my pet has not been determined. I assume full responsibility for this animal.

Anesthetic and Surgery Release

I understand that the administration of anesthesia involves some risk to my pet, including rare reactions to medications and death. I consent to the use of medications as deemed necessary by the veterinarian. I understand that all procedures and surgery also involve some risk to my pet. The most common risks include, but are not limited to; bleeding, nerve damage, infection, and death. I also understand that no guarantees or assurances have been made regarding the outcome of this procedure.

The doctors and staff of Arrowhead Veterinary Hospital, Inc. will use all reasonable precaution against injury, escape, complications, and death. I agree to not hold the doctor and staff responsible under any circumstances. In the event that a life threatening emergency should arise, I:

☐ Authorize veterinary staff to perform lifesaving measures.

☐ Prefer veterinary staff ***not*** perform lifesaving measures.

I have read and fully understand this consent form:

_____ _____
Signature of Owner/Agent Date

_____
Agent's Printed Name (If applicable)

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AVH Patient Check-In

AVH Employee Initials: _____ Dr. being seen: PB_____ ME_____ DN_____ New Patient: ☐ Yes ☐ No

Procedure: _____ Appt. time: _____ Arrival time: _____ Weight: _____

Reason for Visit: _____

Additional requests? _____

Is your pet currently on medication? ☐ Yes ☐ No Medication: _____

Frequency: _____ Dosage: _____Did your pet receive these medications today? ☐ Yes ☐ No

When did your pet last receive food? _____ Water? _____

Histopathology Submission: ☐ Yes ☐ No Other: _____

Dentals: Are extractions okay? ☐ Yes ☐ No Would you like to be called prior to #_____ extractions? ☐ Yes ☐ No

Do you have other concerns? _____

Prior anesthetic problems? _____ Reactions? _____

Current on vaccines? ☐ Yes ☐ No Give? ☐ Yes ☐ No County License? ☐ Yes ☐ No

For your pets protection, AVH, Inc. requires Rabies vaccine to be current and may require vaccination if vaccine has expired. If any of the following vaccines have been given please specify date administered.

☐ Rabies_____ ☐ Da2p+cpv_____ ☐ Bordetella_____ ☐ K9 Influenza_____

☐ FELV _____ ☐ FDRTV _____ ☐ Other _____

Eating? ☐ Yes ☐ No Drinking? ☐ Yes ☐ No Urinating? ☐ Yes ☐ No Defecating? ☐ Yes ☐ No

Behaving normal? ☐ Yes ☐ No Is an estimate needed prior to procedure(s)? ☐ Yes ☐ No

NOTES: _____

_____

_____

Home Again Microchip:

The best time to microchip your pet is when your pet is under anesthesia. The chip is about the size of a grain of rice and is considered to be the best form of permanent identification. The cost of the chip implantation and registration fee is $45.00. Would you like to have your pet microchipped today? ☐ Yes ☐ No

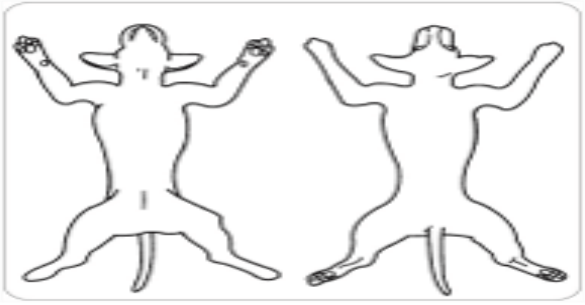
What name and address would you like your pet's microchip registered under? _____

_____

I agree that all the information provided above is true and correct. I also understand that I agree to pay for charges of all scheduled and additional requested procedures listed above.

_____ _____ _____

Initials of Owner/Agent Initials of Reception/Technician Date



Hospital Admission Information and Financial Agreement

Please read the following statements and consents regarding your animal while it is in the care of personnel at Arrowhead Veterinary Hospital, Inc. (AVH, Inc.) and your financial obligation as the result of this care. If you have any questions, please have these clarified before you sign this document or have your animal examined.

I authorize AVH, Inc. to perform medical and diagnostic procedures on the animal identified in this record as required for diagnosis and treatment. Emergency procedures may be needed in life saving situations and may be carried out before I can be contacted. I also understand I must instruct the attending veterinarian if there are financial or medical limitations to emergency care.

Hospitalized animals have an increased risk of infection and injury which may occur in association with hospitalization, diagnosis, and treatment. Precautions are taken to prevent injuries and acquired sickness and AVH, Inc. does not assume costs for treatment. Patients are closely monitored for signs of infection. Reasonable diagnostic testing of clinically affected or suspect animals to detect contagious microorganisms will be performed at the owner's expense. Apparently unaffected animals may also be tested to allow appropriate management of contagious diseases in AVH, Inc. Owners are responsible for costs of special procedures required to manage patients suspected of being infected with contagious microorganisms. Owners will receive updated cost estimates whenever additional testing or precautions are necessary at the owner's request.

As owner or authorized agent of the admitted patient, I authorize AVH, Inc. to administer agreed on diagnostic and treatment procedures and emergency treatment as considered necessary. I understand that it is my responsibility to inform the attending veterinarian about any treatment or diagnostic test that I do not want my animal to receive. An animal left at the Hospital over five (5) working days beyond the recommended dismissal date is considered abandoned. Every effort will be made to contact the owner during this period of time. At this point it will become property of AVH, Inc. The Hospital considers the identification of a referring veterinarian to imply that I authorize a release of medical record information to that veterinarian. AVH, Inc. is continually reviewing medical information to improve patient care.

AVH, Inc., a small privately owned business, does not have the resources to provide 24 hour care and monitoring to our patients. Doctors and staff stabilize all patients prior to leaving for the day. The Veterinary Emergency Center (VEC), an emergent animal hospital located at 1660 North Avenue, Grand Junction, CO, is staffed weeknights, weekends, and holidays. I have the right and option to personally transfer my pet to this facility if I so desire. I assume all risks during transport, and acknowledge that I will have to transfer my pet back to AVH, Inc. during hours that the VEC is closed. If I do not discuss my wishes with a staff member, it is assumed that I have declined this option.

I hereby acknowledge that I have read the above and understand the cited risks. Risks of specific treatment and diagnostic procedures will be explained by attending veterinarians and specific consent forms will be needed. I also understand that no guarantee or assurance can be made to me as to the results that may be obtained.

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the above described pet(s). I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid in full at the time of release and that a deposit may be required for medical and surgical treatment. In the event that my account is past due or outstanding I understand that a $10.00 billing fee will be applied to my account after 30 days and every 30 days thereafter until my account is paid in full. I agree to pay a $25.00 cost of collection in the event that any collection efforts are undertaken for past due amounts. If the services of an attorney are used, I agree to pay reasonable attorneys' fees and all court costs actually incurred.

Pre-payment of fifty percent (50%) of the estimated cost of the procedure may be required as down payment at admission and the total will be due in full at dismissal/discharge. Any cases hospitalized for an extended time will be required to update balances weekly or as deemed necessary by the management.

Method of Payment: ☐***CASH*** ☐***CHECK*** ☐***CREDIT CARD*** ☐***CARE CREDIT***

_____ _____

Signature of Owner/Agent Date

_____

Agent's Printed Name (If applicable)