



Blue Ravine Animal Hospital
1770 Prairie City Rd
Folsom, CA 95630
916.984.0990

**Blue Ravine Animal Hospital
Surgery Release**

Client ID:
Client Name:
Address:

Patient:
Age:
Species:
Breed:
Sex:
Color:

Phone Number:

**** Please complete with blue or black ink****

SURGERY CONSENT

I, the undersigned, do hereby certify that I am the owner (duly authorized agent for the owner) of the animal described above, that I do hereby give Blue Ravine Animal Hospital's attending veterinarian and staff full and complete authority to perform the surgical procedure described as **(owner to complete)**:

I understand that my pet is scheduled for a procedure that requires anesthesia. I realize that any anesthetic/surgical procedure involves some risks including but not limited to: anesthetic reaction, surgical site dehiscence and/or infection, and/or additional medications or treatments as a consequence of unforeseen complications. I understand that pre-anesthetic blood work does not guarantee the absence of complications. It may, however, reduce the risk of anesthesia or require changes in the anesthetic protocol by identifying certain conditions such as diabetes, liver, or kidney disease. I certify that I have notified the doctor of any pre-existing conditions, such as seizures, allergic reactions, previous anesthetic complications, etc. I do hereby forever release the said doctor, her agents, servants, or representatives from any and all liability arising from said surgery on said animal.

I certify that my pet has not eaten any food or treats for at least 8 hours. Initials: _____

Current medication(s) and time(s) given:

***Please note that all patients will receive IV fluids during their surgery and anesthesia recovery (included in your estimate). We will need to shave a small area of a front leg to ensure sterile placement. We may also need to shave a small area of a paw to allow proper blood pressure monitoring. Initials: _____**

PRE-ANESTHETIC BLOOD TESTING CONSENT

We strongly recommend that a pre-anesthetic blood screen be performed prior to anesthesia for patients under 8 yrs old. This may help us avoid possible complications during the procedure. Blood work is mandatory for patients older than 8 yrs old (included in your estimate, if applicable).

Please **initial** your choice below:

- YES, CHEM 10, SDMA, CBC, electrolytes (*only if under 8 yrs of age*) \$146
- NO, I decline pre-anesthetic blood testing.

ADDITIONAL OPTIONS: PAIN MANAGEMENT, SEDATIVES, ELIZABETHAN COLLAR, MICROCHIP PLACEMENT

Pain medications and sedatives are administered prior to surgery, however, we strongly advise additional pain medication and/or sedation at home for most surgical procedures. Too much activity and inadequate pain control may hinder the recovery process. An elizabethan may also keep your pet from causing trauma to the surgery site and is also strongly recommended. You may also elect to have a microchip placed while your pet is under anesthesia.

Please **initial** your choice below:

- YES, dispense additional medication for pain relief at home. \$27-50
- NO, I decline additional medication for pain relief at home.

- YES, dispense sedatives. \$27-75
- NO, I decline sedatives.

- YES, dispense an Elizabethan collar. \$12-20
- NO, I decline an Elizabethan collar.

- YES, Please place a microchip while under anesthesia. This permanent ID can never be removed or become impossible to read. \$65

TREATMENT CONSENT (For dental consent, also complete next section)

In addition to today's procedure, patients occasionally require further treatment based upon the veterinarian's findings and/or patient response to the procedure. If the hospital staff cannot reach me by phone, please do the following:

Please **initial** your choice below:

- YES, please treat my pet as deemed necessary by the attending veterinarians, and I will be responsible for any associated costs. I authorize a maximum of \$ _____
- NO, do not make any major changes in treatment without contacting me first.

DENTAL EXTRACTIONS CONSENT (For dental procedures only)

Dental estimates are created prior to assessing your pet under anesthesia (i.e., prior to dental radiographs). As a result of dental radiographs, the degree of dental disease may reveal the need for extractions.

Please **initial** your choice below:

- YES, please perform all required extractions as deemed necessary by the veterinarian even if it exceeds the provided estimate (i.e., I do not require a phone call).
- YES, please perform all required extractions as deemed necessary as long as the cost doesn't exceed the provided estimate (i.e., I do not require a phone call).
- NO, do not perform any extractions without contacting me. By marking "no" you are acknowledging that your pet will not receive the veterinarian's recommended extractions or treatment and will be awoken from anesthesia if we cannot get a hold of you.

Client Signature (please sign in blue or black ink)

Date

Phone number where you can be reached today: _____