Medical/ Surgical Authorization

PLEASE READ ENTIRE DOCUMENT BEFORE SIGNING!

Owner or Agent (Print):___________________________________ __ Date: _____________________

Address:____

Phone Number(s) While Pet with us: ___________________________ ______________________
Patient: _________________________
Species: Canine Feline Sex: M MN F FS Breed: __________
Color: ___________________

AREAS OF CONCERN other than the problem being admitted for: Vomiting Diarrhea Lethargy Coughing Sneezing Other:____
BLOODWORK: Previously done Declined N/A

Procedure(s):
Estimated costs:____(See attached form for details)

****Please note this is a General Estimate only. Sometimes once the procedure is started additional issues may arise that require further time and exceed the cost estimate.** If the estimate is likely to be exceeded then we will make all possible effort to contact you on the telephone number provided. I f we are not able to contact you within a reasonable time, the doctor will make the decision that is in the best interest of the patient.

☐ I authorize the attending veterinarian and Aldergrove Animal Hospital professional staff to perform any additional procedures deemed necessary and advisable for the maintenance of my pet's health and well being.

☐ Please attempt to contact me if anything additional is needed but proceed if I am not available

☐ Please contact me regarding any additional procedures. **If I am not available, do not proceed**. I understand this may mean my pet will require an additional procedure under anesthesia at a different time.

Consent to Perform Medical Treatment or Surgery:

I am aware that if my pet has a pre existing condition, this may affect the anesthetic protocols and procedures performed.

I am the owner or agent of the animal described above.

I have authority to execute this consent and am over the age of 18.

I , the undersigned, do hereby authorize any veterinarian or qualified staff member of Aldergrove Animal Hospital to carry out and administer to the animal such examinations, treatments, procedures, operations, and anesthetics as may be deemed necessary or advisable or as may be ordered by any veterinarian in attendance.

The nature and purpose of the procedure(s) has been explained to me and I understand that no guarantee exists as to the result of diagnosis and treatment of the said animal.

I have had the fees outlined to me and agree to pay all such fees and charges at the time of discharge, with the understanding that the quote given is an estimate only. I agree to pay, in full, for services rendered, including those deemed necessary for medical or surgical complications or unforeseen circumstances. I assume financial responsibility for the debt incurred for treatment of said animal.

I hereby certify that I intend this document to be a complete release of any liability which might otherwise arise out of any medical or surgical examination or treatment of the animal and that the consequence of this release is fully apparent to me, and that I understand that I can have no claim upon, the hospital or any veterinarian or any qualified member of the hospital staff in the event of any damage to the animal by reason of medical or surgical examination or treatment.

I have read and understand this consent.

Signature of Owner/Agent:____

Date:________________________________Witness:________________________________

Aldergrove Animal Hospital
26841 Fraser Hwy
Aldergrove BC V4W 3E4
(604)856 7707 Fax (604) 856 1255

Form of Payment

Visa_______________
MC_______________
Debit_____________
Cash______________
Cheque____________(Only if pre approved by management prior to this date)
Payment Plan_______(Only if pre-approved by management and specific terms finalized prior to this date. Administration fee may be applied. Payments must be received in the form of preauthorized signed credit card forms or post dated cheques.)