

SURGICAL RECORD

EMERGENCY PROCEDURES AND COMPLICATIONS

AUTHORIZATIONS

I, the undersigned, certify that I am the owner, or authorized agent for the owner, of the above described animal. I authorize the doctor on duty and assistants to perform the above described procedures including administration of sedatives and or anesthetics, as well as any necessary and appropriate medical, surgical, nursing, diagnostic and/or emergency care for the animal. I have been advised as to the nature of the procedures and the potential risks. I also understand that no guarantee of successful treatment can be made. _____

I have read and understand the reasons for and the risks of the above described authorized procedure(s), and assume full financial responsibility for all charges and services incurred to the described animal. _____

I authorize the doctor and assistants to hospitalize the animal described and to perform the medical tests, procedures, and/or treatments listed above. _____

I understand that All Creatures Animal Clinic is not a 24-hour hospital. Should an overnight stay be necessary, direct observation will not be available. If the patient needs observation, transfer to a 24-hour hospital will be recommended. _____

Signature: _____ Date: _____

CURRENT CONTACT INFORMATION

Home Phone: _____	Work Phone: _____
Cell Phone: _____	
Other Responsible Party: _____	Phone: _____