

Canine Neuter Release Form

Owner Name: \_\_\_\_\_

Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ City: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Pet Name: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_

Age: \_\_\_\_\_ Description: \_\_\_\_\_

We strive to provide quality veterinary care for your special companion. To better serve you and your pet; please answer the following questions about your pet.

1. Has your pet had a veterinary exam in the last 30 days?    YES                    NO

    This is highly recommended prior to any surgery.

2. What medications is he/she currently taking?

\_\_\_\_\_

3. What health problems, if any, should be noted? Note past surgeries/anesthesia.

\_\_\_\_\_

\_\_\_\_\_

4. Do you have any specific health concerns for you pet?

\_\_\_\_\_

\_\_\_\_\_

5. Are vaccinations current? Which ones? Where were they done?

\_\_\_\_\_

Below is for office use only. Please circle which vaccinations need done.

DA2PLPC

Virbantel

DA2PPC

Strongid dewormer

Bordetella SQ

CIV

Rabies

Services to be provided:

Surgery: SPAY    NEUTER    DENTALMISC. \_\_\_\_\_

Pre-Anesthesia blood work is required for all animals over 5 years to check for proper kidney and liver function. It is highly recommended for all animals prior to all anesthesia situations, but optional for those under 5 years of age. Unless the doctor feels it is necessary.

YES- I authorize my animal to have pre-anesthesia blood work.

NO- I do not authorize my animal to have pre-anesthesia blood work.

Signature of client: \_\_\_\_\_

Conditions are often found at time of surgery and require care. If you would like these conditions to be treated today, please specify below:

- |  |     |                        |
|--|-----|------------------------|
| 1. Ears- ear mites, cheet, infection, ect. | YES | NO                     |
| 2. Extraction of baby teeth                | YES | NO                     |
| 3. Skin problems                           | YES | NO                     |
| 4. Dental Cleaning                         | YES | NO                     |
| 5. Pain Management                         | YES | NO                     |
| 6. Crypt orchid                            | YES | NO                     |
| 7. Hernia                                  | YES | NO                     |
| 8. Elizabethan Collar (Cone)               | YES | NO _____ Initial here. |

**PLEASE UNDERSTAND THAT THE ABOVE CIRCLED PROCEDURES WILL INCURE EXTRA CHARGES. This includes pregnant animals and any abnormalities found during surgery. Any post surgical complications are not covered in today's bill.**

Surgery and services authorization statement:

***IF YOUR ANIMAL HAS FLEAS OR TICKS WE WILL REAT DUE TO THE CONTAGIOUS NATURE OF THESE PARASITES. THIS WILL INCUR EXTRA CHARGES.***

I authorize the licensed veterinarians of Animal Medical Service to administer such treatments as considered therapeutically and diagnostically indicated on the basis of findings during the course of evaluation. I certify that I have read and fully understand the above authorization of medical and surgical treatment. I also understand fully the risks that go along with anesthesia and surgical procedures. Further I assume financial responsibility for all the charges incurred to my pet.

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

