



# Sedation & Anesthesia Consent Form

8014 Bellona Avenue \* Towson, MD 21204 \* (410) 296 - 0890 \* (410) 296 - 0892 (fax) \*

[www.ruxtonanimalhospital.com](http://www.ruxtonanimalhospital.com)

Owner/Authorized Agent Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Pet Name: \_\_\_\_\_ Species:  Dog  Cat Age: \_\_\_\_\_ Weight: \_\_\_\_\_

Presented For: \_\_\_\_\_

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## HISTORY

Last feeding:	AM / PM	What did they eat?:	How much?:
Have you observed any of the following: <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Coughing <input type="checkbox"/> Sneezing If applicable, describe your selection above or list any other concerns you would like addressed during this visit:			
What medications/supplements is your pet currently on, if any?:			
Will you be needing any medication refills or parasite prevention today?: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what do you need?			

## For Diabetic Patients ONLY

When was their last dose of insulin?: \_\_\_\_\_ How much insulin was given?: \_\_\_\_\_

## ADDITIONAL CARE (charges may apply)

Would you like your pet microchipped while under sedation?:  Yes  No  Not Applicable

Are there any of the following services you would like added to today's visit?:

- Nail Trim                                       Anal Sac Expression                                       Sanitary Clip  
 Nail Trim w/ Dremel                                       Ear Cleaning                                       None

<input type="checkbox"/> I authorize any and all diagnostics/treatment the doctor deems necessary, including but not limited to bloodwork and radiographs. <input type="checkbox"/> I authorize diagnostics/treatment up to the amount of \$_____ <input type="checkbox"/> Please call me prior to performing <u>any</u> diagnostics/treatment.
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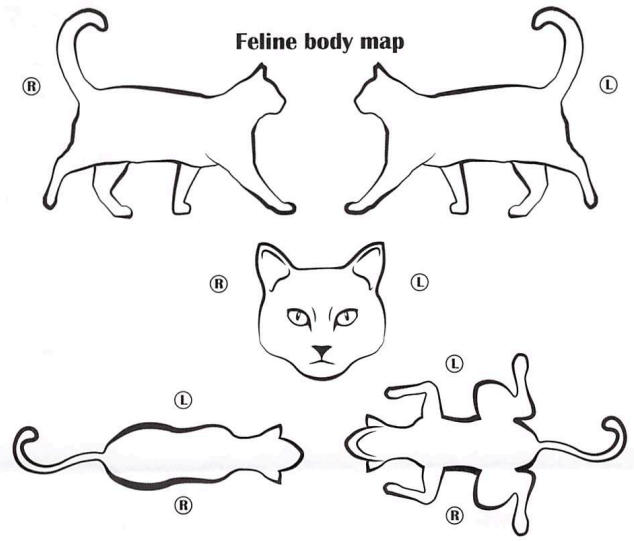
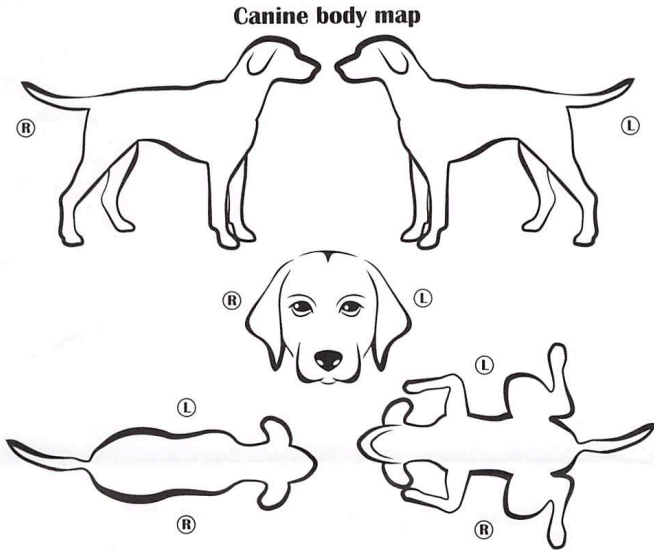
**\*\*NOTE\*\*** For the protection of your pet and other pets in the clinic, we require all drop off patients to be free and clear of fleas, ticks, and/or ear mites. If any of these parasites are discovered on your pet upon examination, treatment and preventative measures will be administered at the owner's expense.

In case of an emergency, if I am unable to be reached at the above listed points of contact, please call:

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

...CONTINUED ON REVERSE SIDE

\* If applicable, mark the area(s) being addressed today on the correlating body map below. \*



Have there been any changes to the marked area(s) since scheduling your appointment?  Yes  No

If yes, please describe: \_\_\_\_\_

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**CONSENT & ACKNOWLEDGEMENT**

I, the undersigned, certify that I am the legal owner or authorized agent of the above stated animal, and consent to the procedure/treatment of this pet by the veterinarians and staff of Ruxton Animal Hospital. I have been advised of the nature of the services and/or operation anticipated and have discussed my concerns with the veterinary staff prior to the procedure/treatment being initiated.

I acknowledge that as with any anesthetic procedure, there is always some risk associated, even in apparently healthy animals. Should my pet require critical intervention, I permit the attending veterinarian(s) at Ruxton Animal Hospital to proceed as indicated in the box below.

Please, select and initial **ONLY ONE** of the following:

- CPR (Cardiopulmonary Resuscitation)** - Perform any and all procedures/treatments necessary to resuscitate. Steps include basic CPR, drug therapy, up to surgical intervention. I will be responsible for any charges accrued as a result of resuscitative procedures. I understand that despite the best efforts of the Ruxton Animal Hospital staff and veterinarian(s), CPR does not guarantee survival and that if my pet's life is successfully restored, they may not regain normal mental and physical health. \_\_\_\_\_ <- INITIAL
- DNR (Do Not Resuscitate)** - Do not perform any procedures/treatments to resuscitate the above named pet in the event of cardiac arrest. In cases of *pulmonary* arrest the attending veterinarian will have the discretion to attempt to establish a functional airway. I understand that every attempt will be made to contact me or the authorized agent for further instruction and accept that if the aforementioned parties are unreachable, permission is granted to the veterinarian to humanely euthanize my pet to prevent further suffering. \_\_\_\_\_ <- INITIAL

I am aware that Ruxton Animal Hospital does not provide 24 hour supervision. If intensive overnight care is required, I may be referred to an emergency clinic or can arrange to have my pet transferred to a 24 hour facility of my choice. I agree that I, or an authorized agent, will pick up my pet during practice hours. In the event pick up occurs after business close, an after-hours fee will be applied to my invoice.

Lastly, I agree to pay for all services rendered at the time of my pets discharge and by signing below I am certifying that I have read and fully understand the terms and conditions set forth above.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The safety and comfort of your pet is our primary concern!

♥ Thank you for entrusting your pet to our care ♥