



60885 S.E. 27th Street

Bend, Oregon 97702

Ph: 541-382-9262

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Authorization and Release for Treatment

Patient _____ Owner _____

Anticipated Procedure: _____

I am the owner of this patient, or the owner's authorized representative.

I authorize the procedures that were discussed and/or indicated above, and agree to be financially responsible for the charges incurred.

I further authorize any additional, unanticipated procedures that may be seemed necessary in this course of treatment. I expect to be advised of such need as soon as possible and feasible.

I am aware that any payment agreements, other than payment at the time of service, must be finalized prior to any services being rendered, and agree to be responsible for any and all legal fees and collections costs, should they be necessary.

_____ I understand that an estimate of anticipated charges is available upon request, but estimates may be exceeded in the event unanticipated problems are encountered. **Would you like an estimate?** ____ YES ____ NO

The risks and alternatives have been explained to me to my satisfaction, and no guarantee of results or cure has been made.

Signature _____ Date _____

Printed Name _____ Phone# _____

Dentistry/Anesthesia/Surgery/Authorization

Client _____ Phone Number _____ Date _____

Patient _____ Sp. _____ Sex _____ Age _____ Brd. _____

Anticipated Procedure _____

Your pet has been scheduled for a procedure that will require either sedation or general anesthesia. Please answer the following questions to help us avoid adverse reactions to medications that could be necessary as part of the procedure.

Is your pet currently on daily medications of any kind? _____

Did you give the medication today? _____

Has your pet had adverse reactions to any medication? _____

Prior General Anesthesia or Sedation? _____ **Problems with anesthesia?** _____

Past or recent history of seizures? _____ **Vomiting?** _____ **Persistent Diarrhea?** _____

Cough or respiratory problems? _____ **Unusual water consumption?** _____

Unusual urination? _____

Was food withheld as directed? _____

Pre-anesthetic Diagnostic Testing

Patients undergoing anesthesia and dental or surgical procedures may require medications such as antibiotics and pain relievers, in addition to the sedative or anesthetic agent, that could cause undesirable or harmful reactions if the patient has pre-existing problems with their heart, lungs, liver, kidneys or other body systems.

Laboratory diagnostic tests and imaging procedures such as radiographs can be used to obtain information about these systems so as to minimize the risks involved.

In patients that are old enough to expect age-related problems or exhibit problems on our physical exam, these diagnostic measures may be deemed mandatory by the doctor.

Even in patients that appear vigorous and healthy, a minimum baseline blood chemistry evaluation is desirable to detect problems that could exist and not be evident on physical exam.

There is no level of testing that will completely eliminate the potential adverse reaction by any particular individual to any particular medication. At all times, we strive to use the safest and most effective anesthetic, antibiotic and pain relief protocols available.

If circumstances exist under which a client would prefer to decline the testing

Recommended above, they may do with the understanding that the doctor will proceed with the information at hand in as safe a manner as allowed with this information, but the client accepts any additional risks and adverse reactions that may result.

Please initial one of the following: I hereby request pre-anesthetic blood testing _____

I hereby decline pre-anesthetic blood testing _____