Singing Hills Animal Hospital
1951 Willow Glen Drive
El Cajon, CA 92019
619-441-585

Technician Check-in Initials: ___________

ANESTHESIA-OVARIOHYSTERECTOMY

Date:__________

Owner:____ Name: _______________________________________

Address: _____________________________________ Breed: _______________________________________

____ Sex: ____

Phone: _______________________________________ Age: ____

Color: _______________________________________

I, the undersigned, do hereby certify that I am the owner (duly authorized agent for the owner) of the animal described above. I do hereby give Dr. Evelyn Tom, Singing Hills Animal Hospital, Inc., their agents, servants and/or representatives full and complete authority to perform the surgery or diagnostic procedure known as **Ovariohysterectomy**. I authorize additional procedures that, at their discretion, may be advisable and useful to promote/protect the health of the above described pet. I do hereby forever release Dr. Evelyn Tom, Singing Hills Animal Hospital, Inc., their agents, servants and/or representatives from any and all liability arising from said surgery or procedure on said animal.

_________________________________**(Signature)**

If my pet should be in heat, obese, or pregnant there will be an additional fee of $54 for cats and $85 for dogs.
_____________________ **(Signature)**

For the safety of your pet, an intravenous catheter and fluids are required during surgery. This increases safety by keeping blood pressures higher, increase perfusion of vital organs, increase speed of clearance of anesthesia, and aid in life saving protocols. The fee is $150. _____________________ **(Signature)**

I understand pain medications will be administered after surgery. _______ (**Initial**)

I understand a chew guard collar is mandatory to keep pets from licking or chewing after surgery. One courtesy chew guard collar will be provided. If lost or damaged, a replacement will be provided for an additional fee. ___________________________(**Signature**)

If fleas are found on your pet, we will administer a treatment to them to prevent the spread of parasites to other pets in the hospital. (Charge of $25). _______(**Initial**)

I understand my pet must have **current vaccinations**. If determined by record or examination that my pet is due for vaccinations, I authorize vaccinations to be performed at my expense. I authorize treatment for external or internal parasites, including fleas, if found on my pet. I understand the hospital is not responsible for any items I may leave, such as: collars, leashes, toys and blankets. ______(**Initial**)

I certify my pet has not eaten within the last 12 hours. _______(**Initial**)

I understand my pet is fasted for surgery, however, if an anti-nausea medication is needed, there will be an additional fee of $85. ____________(**Initial**)

I can be reached at the following phone number/s on the day of the procedure:

Home/Work:_________________ **Cellular:**_________________**Email**___________________

In order to better evaluate the ability of your pet to undergo anesthesia, the doctors recommend a pre-anesthetic blood test for existing infection, kidney, liver, and over organ functions. The fee for this is an additional $119-189 and is mandatory for pets 7 years of age and older.

( ) Accept _________ ( ) Decline _________

_______________________________________ (**Signature**) I have read and understood the above statements.