WILDERNESS ANIMAL HOSPITAL

Pet's name_____ Owner Name_____

Presurgical Consent Form- Feline Castration (neuter)

In order to keep elective procedures affordable, we offer many options for you to feel comfortable with the level of care your pet receives during its surgical procedure.

Pre surgical blood testing
Blood testing to evaluate liver and kidney function and red blood cell count can help us better reduce the risk of anesthetic complications. This test is recommended, but optional for animals less than 7 years old and required for pets over 7 years old (unless blood tests ran within last 3 months were normal)

Cost: $90.00 Accept____ Decline_____

Pain medication
All pets receiving surgery are given short acting sedative and pain medication before surgery.
Although animals are good at hiding their pain, many routine procedures can cause post operative pain. We offer post operative pain medication in hospital and to be sent home for post operative pain control.

Post operative pain medication cost included in cost of procedure. Pain medication given in hospital will be effective for 3 days – this is given at time of surgery.

Pain medication to go home cost: $50-100 (Depending on size of pet) Accept____ Decline_____

Additional procedures:

Physical exam($63)□**Yes** □**No** Vaccination(varies) □**Yes** □**No** Microchip($53) □**Yes** □**No**

Fecal testing ($35) □**Yes** □**No** Toe nail trim **(included)** □**Yes** □**No** Anal glands($25) □**Yes** □**No**

Flea control:
To maintain a flea free environment, any pet admitted to Wilderness Animal Hospital with evidence of fleas will be given a Capstar© tablet to kill the fleas at a cost of $13.00 to the owner.

Food/Medication:
Last time fed:_____AM/PM
Last time medication given:_____AM/PM
Name of medication(s):_____

Release:
I am the owner or caretaker of the pet and am over 18 year of age. I assume responsibility of care after surgery and authorize the doctors at Wilderness Animal Hospital to perform the surgery. While performing the surgery should the doctor find the procedures(s) to be more involved resulting in additional cost, I will be contacted at the phone number below. If I cannot be contacted, I authorize the doctor to perform the necessary procedure at his/her best discretion.
I understand full payment is required when the patient is discharged.

Signature of owner/caretaker_____Date_____/_____/_____

Emergency phone # where you can be reached TODAY (_____)_____-_____