

SURGERY/ANESTHESIA/TREATMENT RELEASE

Client: <first-name> <last-name> Pet: "<animal>" Breed: <breed> Age: <age> Sex: <sex>

Procedure: <appt-notes>

***Please read this document carefully and completely;
answer all questions and SIGN below as indicated.***

****LIST any medications that your pet is currently taking:**

***PAIN MEDICATION POST-OP IS INCLUDED**

Pets receive injections at the time of all surgical procedures for pain relief; they will also take home 3 to 5 days of oral pain medication.

PRE-ANESTHETIC BLOOD SCREENING

Your pet will be receiving general anesthesia; it is to be understood that anesthesia ALWAYS carries some risk. Bloodwork prior to anesthesia is highly recommended for all patients (it is *REQUIRED* for pets 7 years of age and older); this is to insure that organ function is normal.

There is an additional fee for pre-anesthetic bloodwork

- YES**, I want my pet to have pre-anesthetic blood screening ***REQUIRED FOR PETS 7yrs and older**
- NO**, I do not want my pet to have pre-anesthetic blood screening. I fully understand the possible consequences of anesthesia and surgery/dentistry being performed without this vital information

DENTAL (if applicable) **Baby teeth will be extracted as medical necessity and charged accordingly ******

Many problems with a pet's teeth may not be discovered until they are under anesthesia and a complete oral exam can be performed. If it is discovered that your pet has a tooth/teeth that needs to be extracted please indicate your wishes below. Dental Cleaning prices do not include additional dental procedures/extractions

- YES**, the veterinarian has permission to pull damaged and/or infected teeth as medical necessity (\$ varies)
- NO**, I will bring my pet back for another anesthetic procedure (NOT recommended)

NON-SURGICAL EXAM: Requests for treatment other than the surgical procedure *will incur an additional cost*

- YES**, I would like my pet examined for _____
- NO**, my pet does not need any additional examination other than for surgery today.

HOME AGAIN MICROCHIP

- YES**, I want my pet to be microchipped
- NO**, I do not want my pet microchipped **OR** Pet is already microchipped

***What ONE EMERGENCY phone number can we READILY CONTACT you today? _____

I have read and understand the above document and hereby authorize Lone Star Animal Hospital to perform the indicated treatments and/or procedures for pet, assuming all risks and financial responsibility.

SIGN _____ DATE ____/____/____

CLIENT INFORMATION

Name <first-name> <last-name>
Address <address> <city>, <st> <zip>
Phone (<area>) <phone>

Client/Pt <number> / <[Patient-Record
Number]>
Email <e-mail>
Cell Phone <cell-phone>

PATIENT INFORMATION

Name "<animal> "
Sex <sex-name>
Age/DOB <age> (<birthday>)
Allergy <allergy>
Species <species>
Breed <breed>
Color <color>
Microchip <id>

Sx & Treatments: _____

Weight _____ Temp _____ P _____ R _____

[] PAB: NO YES Chem 12 / Chem 6
[] PCV: TP:
[] IV CATH: NO YES
Size: _____ Rate: _____
[] PMP: NO YES FIRST []

[] Ace: [] Torb:
[] Diazepam:
[] Midazolam: Ketamine:
[] Dexmedetomidine:
[] Propofol:
[] Penicillin:
[] _____:

NOTES:

ET size: Mask: Iso / Sevo
Gas Start: Stop: Total:
Recovery: smooth rough slow quick vocal

Physical Exam Checklist

1) General Appearance <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	2) Eyes <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	3) Ears <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
4) Respiratory <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	5) Digestive <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	6) Integumentary <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
7) Lymph <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	8) Circulatory <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	9) Neuro <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
10) Genitourinary <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	11) Skeletal <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	12) Abdominal <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

Post-Op Monitoring

Time: _____

TPR: _____