PRESIDIO WAY VETERINARY HOSPITAL

Hospitalization Consent Form

PLEASE READ AND FILL OUT COMPLETELY

Owner's Name:	**Patient Name:**
Co-Owner's Name:	**Dog Walker/Caretaker Name:**

Primary Phone Number	*Alternative Phone Number*	*Alternative Phone Number*

My pet is being hospitalized today for:

In addition, I would like the following to be completed during my pet's stay:

☐ Microchip	☐ Nail Trim	☐ Anal Glands	☐ Fecal Test	☐ Bath	☐ Medical Exam *(For Boarding)*

Your pet is being admitted today the procedure(s) listed above. We will perform a full examination on your pet before administering any anesthetic. For the safety of your pet, we *require* all patients to undergo general wellness laboratory tests prior to administering anesthetic.

SURGICAL ANESTHETIC RELEASE

Is your pet currently taking medications? If YES (Please list below) NO

Medication	***Last dose given***	***Next dose due***	***Refill Needed***

Is your pet allergic to any medications?	***If YES (Please list below)***	***NO***
1.	2.	3.

Has your pet been fasted?	YES	NO	Time meal was given:	
Has your pet been vomiting?	NO	YES	How often?	Last time?
Have you noticed any weight gain/loss?	NO	YES	Explain:	
Has your pet been coughing or sneezing?	NO	YES	How often?	Last time?
Has your pet had normal bowels/urination?	YES	NO	Explain:	
Has your pet had any other symptoms?	NO	YES	Explain:	
To the best of my knowledge my pet is healthy.	YES	NO	Explain:	

DENTAL	**Initial One**
If medically advised for the health of my pet, I consent to any extractions determined necessary.	
I authorize cleaning and dental sealant ONLY.	
If extraction is necessary please wait for consent. If I cannot be reached I would prefer my pet re-anesthetized at a later date.	
DO NOT extract any teeth, even if medically indicated.	

CONSENT	**Initial ALL**
I authorize testing such as X-Ray's and Blood tests determined necessary by the veterinarian.	
If I cannot be reached at the numbers listed above, I authorize the veterinarian to make medically appropriate decisions without my consent. I agree I will be responsible for additional fees accrued.	
I understand the risk associated with anesthetic and surgery.	

Signature	**Date**

Estimate Given ☐