

Okinawa Branch Veterinary Treatment Facility
ANESTHESIA/SURGERY/PROCEDURE CONSENT FORM

OWNER NAME: _____ PET NAME: _____
LAST 4 of SSN: _____ SPECIES: _____
BREED: _____
SEX: Female Male

PHONE NUMBER (Day of procedure): _____

PET SURGERY CONSENT:

_____ I hereby consent and **authorize** you to **prescribe for, treat or operate** on my privately owned animal for which I have shown proof of ownership. I further authorize the veterinarian at the Okinawa VTF to perform the following procedures:

ANESTHESIA RELEASE:

_____ I understand the nature and purpose of the above requested procedure, possible alternative methods of treatment, the risks involved, and the possibility of death. I **authorize the above-named procedure** during the course of the above-named operation. I acknowledge that no guarantee has been made to me concerning the results of the operation or procedure. I understand there are risks associated with anesthesia and give permission for my animal to be anesthetized. While these risks may be recognized and are actively mitigated, they may be severe to include patient death. I authorize the use of appropriate anesthetics, and/or medications, and I understand that the hospital support personnel will be employed as deemed necessary by the veterinarian.

_____ If my pet experiences cardiac arrest I **DO / DO NOT** want any life saving procedures performed.

PRE-SURGICAL BLOOD WORK CONSENT:

I understand that in the best interest in medicine and quality of care that blood test can help determine the general health of my pet and they are recommended to be performed.

_____ I **DO / DO NOT** authorize performing pre-surgical blood tests. I understand that if I choose this option, there will be an additional fee on top of the surgical and anesthetic procedures.

The veterinary clinic is to use responsible precautions against injury, escape, or destruction of the animal. You will not be liable or responsible for the care, treatment, or safe keeping of the animal described above, or otherwise in connection they're with, as it is thoroughly understood that I assume all risks.

I authorize the disposal by authorities of the present medical facility of any tissues or parts, which it may be necessary to remove during requested operation or procedure.

I understand that photographs and movies may be taken during this operation, and that various personnel undergoing training or indoctrination at this or other facilities may view them. I consent to the taking of such pictures and observation of the operation by authorized personnel with the following conditions: the name of the patient and said family is not used to identify pictures: said pictures be used for purposes of medic/dental study or research.

I have read and understand this authorization and consent form. I further understand that I assume all financial responsibility for all services rendered

Signature of Owner **Date**

Signature of Witness **Date**