

ALL ANIMAL VETERINARY SERVICES



2264 Route 32 Modena, NY 12548

Phone: 845-255-2900

Fax: 845-255-5285

Canine Surgery Consent

Owner's Name _____ Phone _____ Alt Phone _____

Address _____ City _____ State _____ Zip _____

Patient name _____ Breed _____ DOB _____ Sex _____

Please Select the additional services you would like performed while your pet is in our care.

Service	Yes	No
Canine Distemper Vaccine		
Rabies Vaccine		
Bordetella		
Lyme Vaccination		
Pre-surgical Bloodwork		
Pre-surgical ECG		
Heartworm/Lyme Test		
Nails		
Anal Glands		
Flea Treatment		
Dewormer		
Fecal Exam		
Microchip		
Date of last heat cycle (Females only)		

Surgical Consent

I am the owner or the agent for the owner of the animal described above, and I have the authority to execute this consent.

I hereby consent and authorize **Dr. Acworth** to perform the following procedures or operations:

I have also been informed that there are certain risks and complications associated with any operation or procedure of this type. The risks have been explained to me, I have had the opportunity to ask questions, and I feel my questions have been answered. I further understand that during the course of the operations or procedures, unforeseen conditions may arise that may necessitate the performance of additional procedures. I understand the clinic staff will notify me at the above listed numbers. I authorize the use of appropriate anesthesia and pain relief medication as needed before, during, and after the procedure. I have been informed that there are risks associated with the use of any medication. DNR [] I understand the hospital support personnel will be used as deemed necessary by the veterinarian.

Signed: _____

Date: _____