

**AUTHORIZATION FOR PROFESSIONAL SERVICES AT  
SANTA CRUZ ANIMAL CLINIC**

The following information is necessary in order that we might serve you better and give you personal attention. **Please fill out the form completely.**

**OWNER'S NAME:** \_\_\_\_\_

**NAME OF ANIMAL:** \_\_\_\_\_

**We MUST have a phone number where you can be reached while your pet is in the clinic.**

**TELEPHONE NUMBER** \_\_\_\_\_ **( IMPORTANT )**

I am the owner or agent for the owner of the above described animal and have the authority to execute this consent. I hereby consent and authorize the **performance of the following procedure(s) or operation(s):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The nature of such service has been described to me to my satisfaction and I realize the neither guarantee nor warranty can ethically or professionally be made regarding the results or cure. I understand the anesthesia carries some risk (even though it may be small). Therefore, blood testing is recommended before general anesthesia. The anesthetic agent is removed from the body by the kidneys and the liver and any pre-existing anemia can increase the risk of anesthesia. It is important to know before anesthesia that these systems are functioning properly. Bloodwork helps us to make this determination. Pain medication will be administered and dispensed as needed. During surgery your pet's heart rate, respiration, blood pressure, and PO2 will be monitored.

**I ACCEPT** THE BLOODWORK \_\_\_\_\_ **I DECLINE** THE BLOODWORK \_\_\_\_\_

**HOME AGAIN MICROCHIP YES** \_\_\_\_\_ **NO** \_\_\_\_\_

- **If your pet** is in heat, pregnant, has been recently nursing, or is obese, these will be an additional charge to spay your animal. (Cost varies from \$15.00 to \$25.00)
- **If your pet** is presented to the clinic for surgery with fleas, it will be given a safe systemic flea medication to eliminate the fleas. The cost for this service is \$5.00.

I understand that I assume financial responsibility for all services rendered, and the payment is due on the date of surgery. Any medications and supplies purchased will be at an additional charge.

**Signature** of Owner or Agent: \_\_\_\_\_ **Date:** \_\_\_\_\_

**Checked in by:** \_\_\_\_\_