



Animal Care Associates, Inc.
 "Caring People-Caring for Animals"[™]
 840 Oakwood Road
 Charleston, WV 25314
 304-344-2244 ~ www.acawv.com



Hospital/Surgical Admission Statement

Owner _____ Pet's Name _____

AUTHORIZATION FOR MEDICAL AND SURGICAL TREATMENT

I hereby authorize and direct the veterinarians of Animal Care Associates, Inc. to perform the indicated procedures and additional diagnostic and/or treatment procedures as deemed advisable and necessary for my pet.

The nature of the procedure(s) has been explained to me and no guarantee has been made to me as to the results or cure. I understand that there may be risk involved in these procedures.

ANESTHETIC RISKS

Although there is no guarantee, appropriate anesthesia is the most important variable in assuring the survival of a patient in any given surgical procedure be it routine spay or a complex orthopedic surgery. To minimize risk we choose the appropriate anesthetic agent for your pet, we recommend a Pre-operative (Pre-op) work-up to detect problems that otherwise go undetected and pose a danger to the anesthetized patient.

We ask you to allow us to perform one of these Pre-operative test(s) on your pet: *Please check any applicable boxes below.*

At Animal Care Associates our doctors recommend pre-operative blood screening for a basic test of your pet's organs (liver and kidneys) to ensure they are functioning properly to remove the anesthesia from the body. An additional test is a Complete Blood Count (CBC) used to measure and evaluate cells that circulate in the blood. A CBC is useful as a screening test for underlying infection, anemia and illness.

- Pre-Op Panel Yes No
- OR**
- Pre-Op Panel with CBC Yes No

We recommend pain management for your pet following any surgical procedure: *Please check any applicable boxes below.*

- Please send pain management home with my pet Yes No
 If you would like an estimated cost of pain management please ask the receptionist

Would you like us to perform these additional services to ensure your pet's future well being?

- Glaucoma Screen Yes No
- Home Again Microchip Yes No

All Services of this hospital must be paid before a pet can be released.

I agree to pay, in full, for services rendered, including those deemed necessary for medical and surgical complications or unforeseen circumstances.

I have read the above conditions of this hospital. I consent for the above procedure to be performed and I understand the need for the procedure and the risks involved.

All animals entering the hospital should be up to date on vaccinations and must be free of external parasites (fleas, ticks, etc.) and internal parasites (worms) or they will be treated upon entry at the owner's expense.

Pets are released only during regular office hours. Any animals not claimed on the tenth (10) day from the date that animal is ready to be released or that any bill, charge or fee becomes due and payable, shall be transferred to any humane society or rescue. Humane disposal of any unretrieved animal shall not relieve the owner or agent of any financial obligation incurred for treatment, boarding or care by the veterinarian.

Date: _____

PRINTED name of responsible owner or agent: _____

Signature of responsible owner or agent: _____

Primary or emergency phone number to be called during pet's stay _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Payment will be made by:

- Cash Check Master Card Visa Discover American Express Care Credit

Office Use Only:

Type of Surgery or Procedure _____

Histopath Yes No **Radiology** Yes No **Laboratory** Yes No

Other _____