LITTLE SENECA
ANIMAL HOSPITAL

20630 Seneca Meadows Parkway, Suite E2
Germantown, Maryland 20876
(301) 540-8670 www.myLSAH.com

HOSPITALIZATION AND SURGERY AUTHORIZATION

AUTHORIZED PROCEDURE (S)_____

OWNER_____**PET'S NAME**_____

SPECIES_____**BREED**_____**AGE**_____**SEX**_____**COLOR**_____

I am the owner (or agent of the owner) of the animal described above. I authorize and request you to hospitalize this animal for purposes of diagnosis, treatment, surgery, or other procedures as specified by this release. I approve the use of whatever anesthetics you deem advisable for the well-being of the animal.

I understand that you will use reasonable precautions to assure the animal's safety while it is in your care. I realize that no guarantee or warranty can ethically or professionally be made regarding the results or cure.

Veterinary service is provided during closed hospital hours as deemed necessary in the judgment of the veterinarian in charge.

We Do Not Provide 24-Hour Supervision.

PLEASE INITIAL THE FOLLOWING STATEMENTS INDICATING FULL UNDERSTANDING OF RESPONSIBILITY.

_____I am the owner of the above described animal

OR

_____I am the authorized agent for the owner of the above described animal and have the authority to execute this consent

_____I am over the age of 18

_____I understand that I assume financial responsibility for all services rendered and that payment in full is due on the date of the service.

_____Should my pet be in heat or have another circumstance that requires special attention during a Spay or Neuter surgery, I agree to pay any additional charges that might apply.

_____Should my pet need extractions due to mobile, decayed, or diseased teeth, I agree to pay any additional charges that might apply.

Yes / No **DO YOU NEED TO BE CALLED TO AUTHORIZE ANY EXTRACTIONS YOUR PET MAY NEED?**
(please be aware that this will take additional time while your pet is under anesthesia)

If you selected "yes" to the above question, please answer the following

Yes / No **IF YOU ARE NOT AVAILABLE WHEN YOU ARE CALLED, DO YOU AUTHORIZE EXTRACTIONS?**
(In the best interest of your anesthetized pet, we will need to know how to proceed with their procedure)

Yes / No **Do you need an estimate for today's services?** Initials: _____

SIGNATURE_____
(Owner or agent of owner)

TGH Time:

PHONE # TODAY_____
Ms. Mrs. Mr. Home Work Cell Pager

DATE_____

FOR OFFICE USE:

Does your pet have any sensitivities or allergies to any drugs or anesthetics?
Yes_____ Not Known_____

Does your pet experience seizures or have epilepsy?
Yes_____ Not Known_____ If Yes, please explain_____

Is your pet on Heartworm Preventative now? Yes_____ No_____ When was he / she last tested for Heartworm? _____

Do you need a refill on Heartworm Prevention today? Yes_____ No_____

If "yes", please circle which preventative and quantity: SIMPARICA TRIO / HEARTGARD / REVOLUTION

1 BOX (6 MONTH SUPPLY) / 2 BOXES (12 MONTH SUPPLY)

Withheld food & water after midnight?: Yes / No/ Na ABX?: Yes / No/ Na

Microchipping?: Yes / No / Done Laser?: Yes / No TNT?: Yes / No