TOWNE SQUARE ANIMAL HOSPITAL
4804 Towne Square Ct.
Owensboro, KY 42301

Client ID:	**{ID}**	Patient ID:	**{PATIENTID}**
Client Name:	**{FULLNAME}**	Name:	**{NAME}**
Address:	**{ADDRESS1}**	Species:	**{SPECIES}**
	{ADDRESS2}	Breed:	**{BREED}**
	{CITY}, {STATE} {POSTALCODE}	Sex:	**{SEX}**
Telephone:	**{PHONENUMBER}**	Color:	**{COLOR}**
Date:		Birth Date:	**{BIRTHDATE[SHORT]}**

We highly recommend with any general anesthesia that you have a pre-surgical blood profile run on your animal. These blood tests will help us to assess the health status of your pet and determine if there are any additional precautions we need to take before surgery.

CBC - checks for anemia, infection & certain bleeding abnormalities
PREP PROFILE - checks for liver, kidney & blood sugar abnormalities
ECG - checks for abnormal rhythms & heart rates
FELV/FIV - feline leukemia virus/feline form of HIV

Recommended Tests for Dogs:

_____CBC
_____Prep Profile
_____EKG (optional)
(Please Initial)

Recommended Tests for Cats:

_____CBC
_____FELV/FIV
_____Prep Profile
_____EKG (optional)
(Please Initial)

Prep Profile is Recommended for all Dentals

I DO _____ DO NOT _____ wish to have the pre-surgical testing run today. **(Please initial).**

Pain Management:

We believe controlling our patient's pain is important. Unrelieved pain can lead to harmful physical effects and may delay healing. Medication may be administered before, during and/or after your pet's medical procedure to reduce pain and discomfort and to promote recovery.

_____ Yes, I do authorize pain medication for my pet. **(Please initial)**
_____ No, I do not authorize pain medication for my pet. **(Please initial)**

Signature:_____

Anesthetic Authorization:

I hereby authorize Towne Square Animal Hospital LLP to perform procedures, operations and associated anesthesia. I understand that unforeseen conditions may require an extension of a planned procedure or operation. I hereby consent and authorize that performance of such procedures, or operations as necessary and advisable in the professional judgment of the veterinarian. I understand some dental procedures may require extractions. I have been advised of the risks involved with the administration of anesthesia. I have read and understand this authorization and consent form.

Circle Procedure: Surgery Dental X-Ray Other:_____

Signature:_____ Date:_____ Phone Number:_____

Microchipping/Permanent Identifying System:

"Microchipping" is a great method of permanently identifying your pet. Should they become lost or stolen, our patient/your pet can be positively identified. Even if your pet has lost their collar, they can be safely returned to you rhome after they have had a microchip injected. The cost of the "microchipping" is.

_____ **I DO** want my pet to be "Microchipped" today. **(Please initial)**
_____ **I DO NOT** want my pet to be "Microchipped" at this time. **(Please initial)**

Signature:_____ Date:_____

E U T H A N A S I A C O N S E N T F O R M

DATE: _____

AS OWNER, OR DULY AUTHORIZED AGENT OF THE OWNER, OF THE ANIMAL PRESCRIBED HEREON. I HEREBY CONSENT TO AND ORDER EUTHANASIA TO BE PERFORMED ON SAME FOR HUMANE REASONS. I FURTHER AUTHORIZE THE ATTENDING VETERINARIAN TO DISPOSE OF THE REMAINS IN ACCORDANCE WITH HOSPITAL POLICY.

TO THE BEST OF MY KNOWLEDGE AND BELIEF THIS ANIMAL HAS NOT BITTEN ANY PERSON DURING THE FIFTEEN (15) DAYS PRECEDING THIS DATE.

SIGNATURE_____

ANIMAL'S NAME_____

SPECIES_____

BREED_____

SEX_____

AGE_____