

**Quail Ridge Animal Hospital**  
937 Mica Dr. #18 ~ Carson City, NV 89705  
775-267-4888 ~ Fax – 775-267-3337

**Authorization for Anesthesia and/or Surgery**

Client's Name: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

Pet's Name: \_\_\_\_\_

Anesthetic and surgical procedure(s) to be performed: \_\_\_\_\_

Surgery Options:

- | <b>Y</b>                 | <b>N</b>                 |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Pre-operative blood work – Cost <b>\$43.50</b> (under 5yrs) <b>\$85.50</b> (over 5yrs) & <b>\$138.11</b> (senior profile) |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous blood work performed within the last 30 days.  |
| <input type="checkbox"/> | <input type="checkbox"/> | Fluid therapy during surgery –recommended – <b>required on patients over 5yr- \$60-</b> Dentals included                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Boarding of patient overnight - <b>\$25.00/night</b>  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain Meds to go home <b>\$22.00</b> (medication included in spay/neuter & cat declaws is in pill form)                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Anal Glands expressed during surgery - <b>\$18.00</b>   |

I, the undersigned owner or agent of the owner of the pet identified above, certify that I am eighteen years of age or over and authorize the veterinarian(s) at Quail Ridge Animal Hospital to perform the above procedure(s). I understand, that some risks always exists with anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian/technician before the procedure(s) is/are initiated. My signature on this form indicates that any questions I have regarding the following issues have been answered to my satisfaction:

- Reasonable medical and/or surgical treatment options for my pet
- Sufficient details of the procedure(s) that will be performed
- How fully my pet will recover and how long it will take
- The length and type of follow-up care and home restraint required
- The estimate of the fees for all services and any necessary payment arrangements

I understand that if overnight care is needed for my pet, Quail Ridge Animal Hospital does not have staff on site between the hours of 6:00pm-7:30am and my pet will be left unattended. An alternative emergency hospital for overnight care will be offered. \_\_\_\_\_.

While I accept that all procedures will be performed to the best of the abilities of the staff at this hospital I understand that no guarantee or warranty has been made regarding the results that may be achieved. I agree to pay a deposit of the estimated fees, assume financial responsibility for the remaining fees, and provide payment via cash, credit card, or check at the time my pet is discharged from the hospital. **Should unexpected life-saving emergency care be required, the staff \_\_\_\_\_ has/\_\_\_\_\_ has not my permission to provide such treatment and I agree to pay for such services.**

I have read and fully understand the terms and conditions set forth above.

Signature of Owner: \_\_\_\_\_ Date: \_\_\_\_\_