Vista Pet Hospital
Surgical & Anesthesia Release Form

Today's Date _____

Owner's Name _____

☐ I am not the owner *but* have permission from the above listed owner to admit this pet.

Phone Number _____ **Additional Number** _____

Owner Email Address_____

Patient's Name _____ **Procedure(s)** _____

Current Medications_____ **Date/time of last dose**_____

Pertinent medical history_____

2nd Patient Information (if applicable)----------

Patient's Name _____ Procedure(s) _____

Current Medications_____ Date/time of last dose_____

Does your pet need any additional services? Please circle Yes or No for all of the following:

Yes | No	Vaccinations **Please List** _____	
Yes | No	Feline Aids/Leukemia Test	$39
Yes | No	Deep Ear Clean	$20
Yes | No	Cone/Collar (for post-op healing)	$7.50-$16 (price varies by size)
Yes | No	AVID Microchip	$47 (AVID charges an additional $20 if you choose to change registration from Vista to personal information)
Yes | No	*****Pre-Anesthesia Blood Panel	$46

***Explanation of Blood Panel:** This blood panel is performed in-house prior to anesthesia. It will show chemistry values for your pet's liver and kidney functions to ensure the anesthesia will be processed safely. This blood panel cannot, however, show if your pet is allergic to anesthesia.
We recommend this panel for any pet over 8 yrs old that has not had lab work within the past six months.

Vista Pet Hospital is to use all reasonable precaution against injury, escape, or death of my pet. Vista Pet Hospital will not be held liable or responsible in any manner whatsoever or under any circumstances in connection therewith, as it is thoroughly understood that I assume all risks. I understand the use of anesthesia always has a certain amount of risk associated with it. I authorize the use of such anesthesia and consent to the administration of medical and surgical treatment as necessary.

Further, I understand that all fees are due in full at time of service and I agree to pay those fees. I also understand that if I received an estimate for today's services it does not determine my final charges. I will be responsible for all finance, collections, and attorney fees incurred if I do not pay these charges.

Owner or Agent Signature: _____

DENTAL PATIENTS ONLY:

I accept this as notification that multiple dental extractions (tooth removal) may be medically necessary and will be performed at the doctor's discretion.

Owner or Agent Initials: _____