DANADA VETERINARY HOSPITAL, P.C.

10 WEST LOOP RD.
WHEATON, IL 60189

SURGERY RELEASE FORM

DATE:_______________

ALL PETS MUST BE CURRENT ON VACCINATIONS AND FREE OF PARASITES WHILE HOSPITALIZED. ANY VACCINATIONS THAT ARE DUE MUST BE DONE AT LEAST 7 DAYS PRIOR TO SURGERY/MEDICAL TESTING AND PARASITES TREATED AT THE OWNER'S EXPENSE.

I hereby consent and authorize Danada Veterinary Hospital/ Drs. Dane, Wallach, Kelly, Hiller, Norberg, Berley and Robbins to receive, prescribe for, treat or operate upon ____ owned by ____.

Danada Veterinary Hospital is to use all reasonable precautions against injury, escape or death of the animal(s), but will not be held responsible in any such event. I understand Danada Veterinary Hospital is not a 24-hour care facility and hospital personnel may not be present outside normal business hours.

I understand that during the performance of any procedure or operation, unforeseen conditions may necessitate an extension of, or addition of, a procedure or operation. Therefore, I consent to and authorize the performance of such as are deemed necessary by the veterinarian's professional judgment. I understand there are risks involved in putting any animal under anesthesia and I realize that results cannot be guaranteed. I also authorize the use of appropriate anesthetics and other medications and I understand that the hospital support personnel will be employed as deemed necessary by the veterinarian.

SERVICES REQUESTED:

SURGERY ______ (pre-surgical blood panel, nail trim and IV fluids included)

Spay _________ Neuter _____ Declaw (2 or 4) ___________ Dentistry/tooth extraction __________

Growth Removal ______ Location of growth ________________________ Other _______________________

DIET: dry _________________________ canned ______________________ other ______________
(circle) am pm free feed am pm free feed

VACCINES NEEDED: Will be confirmed at check in

Distemper (1 yr / 3 yr) _________ Rabies _________ Bordetella (SQ / IN) _________ Stool Check __________

Heartworm test ______ Lepto ______ Lyme ______ Leukemia _______

Microchip Implantation and Home Again Registration ($41.99) _________

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.
PATIENTS WILL NOT BE RELEASED WITHOUT PAYMENT IN FULL.

CONTACT PHONE: Day ______________________ Night _____________________________________

I have read, understand and consent to the above: ____
owner/representative's signature