

## Hospitalization Consent

10/12

Owner/Agent	( )	AM	PM
Emergency Contact #	Admittance Time		
Address	City	State/Zip	
Pet's Name	Breed	Age	
Preexisting Conditions	Color	Wt	

**Reason for admittance, primary complaint(s), preexisting illness, concurrent disease process:**

**IS YOUR PET:**

Allergic to any medications?	YES	NO	Prone to seizures or had any in the past?	YES	NO
Currently on any medications?	YES	NO	A heart patient or special conditions?	YES	NO

If you have answered YES to any of the above questions, please explain:

**Consent for Treatment (Initial to Show Consent - Required unless labeled OPTIONAL)**

\_\_\_\_\_ I am the owner/agent/Good Samaritan responsible for the animal described above, over the age of 18, with authority to execute this consent.

\_\_\_\_\_ I authorize and direct the health professionals of this hospital to perform medical examinations and procedures for the purposes of improving the health of my pet. I acknowledge that the nature and purpose of said procedure(s) have been explained to me. I further understand that no guarantee exists or has been promised to me as to the result of diagnosis and treatment of said animal. I understand that some risks always exist with medical procedures, including anesthesia and/or surgery, and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before procedures are initiated.

\_\_\_\_\_ I acknowledge that fees and charges have been explained to me, and I agree to pay all such fees and charges in full at the time of discharge for services rendered – including those deemed necessary for medical or surgical complications or unforeseen circumstances. If this animal is hospitalized, I agree to pay a deposit of 50% of the estimated fees and assume financial responsibility for the balance of all services rendered on a cash, credit or check basis at the time the pet is discharged from the hospital.

\_\_\_\_\_ I understand that it is my responsibility to call the hospital at least every twenty-four hours to inquire as to the medical status of my pet and the fees incurred for medical services up to that day.

\_\_\_\_\_ I agree that either I, or an authorized agent on my behalf, will pick up this pet and pay for all accrued charges within 24 hours after receiving written or oral notification that this animal is ready to be released from the hospital, unless prior agreements with the hospital are made in advance and entered into my patient/client record. Such notice will be given at the phone number and/or address maintained in my patient/client record. I agree that if I fail to comply, this practice may handle this abandonment in the best interest of the animal and of the hospital, in accordance with to the law, and I will still be responsible for all fees incurred.

\_\_\_\_\_ (OPTIONAL) I hereby authorize the veterinarians and healthcare professionals of this hospital to undertake treatments and procedures beyond those explained to me if deemed necessary to respond to unforeseen complications or circumstances after reasonable efforts to reach me have been exhausted.

\_\_\_\_\_ (OPTIONAL) In the event of a life-threatening complication, I authorize and direct doctors and medical professionals of this hospital to attempt resuscitation of my pet.

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### Consent for Laboratory Work and NSAIDs

\_\_\_\_\_ I understand that most adverse reactions to Nonsteroidal anti-inflammatory drugs (NSAID) are mild but some can result in permanent organ impairment or even death. Therefore I understand that it is my responsibility to call Saint Francis Veterinary Center or the nearest veterinary healthcare facility, should my pet experience any of the following:

- Vomiting
- Decreased or increased appetite
- Notable increases or decreases in water intake
- Change in bowel movements such as diarrhea or black, tarry or bloody stools
- Yellowing of gums, skin or whites of the eyes (jaundice)
- Increased or decreased activity level, incoordination, seizures or aggression
- Change in frequency of urination and/or color or smell of my pet's urine
- Changes in the skin such as redness, scabs or scratching

\_\_\_\_\_ I understand that a thorough history and physical examination is recommended prior to the initiation of NSAID therapy. I accept that to recognize problems that could occur and minimize them during treatment, doctors and staff at this practice have recommended screening my pet prior to treatment by performing laboratory tests to verify healthy organ function and establish baseline blood values and then to monitor changes in lab test results at intervals during long term treatment.

### Select One of the Following:

\_\_\_\_\_ The need for these examinations and tests has been explained to me. I accept the costs incurred. I authorize and direct this facility to proceed with them and, if deemed appropriate, prescribe NSAIDs.

OR

\_\_\_\_\_ The need for these examinations and tests has been explained to me but I elect NOT to proceed with them. Nonetheless, I consent to the provision of the prescribed NSAIDs.

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\_\_\_\_\_ I accept that veterinary medicine is an inexact science and that no guarantee of successful treatment has been made. I have read and understand the above information and accept the specific terms and conditions set forth herein. In the event I do **not** authorize the recommended pre-treatment blood analyses for my pet, fail to follow through with the recommended periodic lab tests or fail to notify the attending doctor of the above side effects, I agree to hold the attending doctor(s) and staff at this facility and the drug manufacturer harmless for any complications that might have been detected and/or avoided.

I have fully read this consent information and understand its contents, implications and purpose.

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Owner/Agent Signature

Date