

Surgery Consent Form  
North Carroll Veterinary Service, Inc  
1929 Albert Rill Road.  
Hampstead, MD. 21074  
410-239-3713

Owner's Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone ( Home ) \_\_\_\_\_ ( Work ) \_\_\_\_\_

Cell Phone \_\_\_\_\_

Animal's Name \_\_\_\_\_ Species \_\_\_\_\_

Breed \_\_\_\_\_ Color \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_

I, being responsible for the above described animal, have the authority to grant you my consent to receive, prescribe for, treat and/or operate upon my pet. I understand the surgery or treatment contemplated is:

\_\_\_\_\_  
\_\_\_\_\_

You are to use all reasonable precautions against injury, escape or death of my pet, but you will not be held responsible in any manner in connection therewith as it is thoroughly understood that I assume all risks .

I also understand that my animal will be updated on vaccines and treated for parasites if necessary.

Preoperative blood work will be performed on your animal before giving anesthesia. The cost for the blood work is \$49.75.

Pain medication and antibiotics will be prescribed for your pet as a precaution after surgery.

All charges shall be paid upon release of the animal.

After carefully reading the above, I have signed in agreement.

Owner \_\_\_\_\_