

Permission to Operate/Treat:

Admission Date: _____ File# _____

Owner's Name: _____ Pet's Name: _____

Surgical Procedure: _____

I verify I am the owner (or Authorized agent for owner) of the above named pet. I authorize Three Counties Animal Hospital to perform surgical/treatment procedure (as stated above), on the above named animal. Additional pain medication may be recommended and at an additional cost. See below.

Should unexpected life-saving emergency care be required, the staff of Three Counties Animal Hospital has my permission to provide treatment. I understand that the owner is financially responsible to Three Counties Animal Hospital for all applicable charges related to this animal regardless of outcome. I also understand the estimated cost for this procedure(s) is

_____.

Owner's Signature: _____

Daytime Phone number: _____

I wish my pet to have a postoperative pain injection _____
I would like additional pain medication to be dispensed for home use. _____

Microchip: Yes _____ No _____

E-Collar: Yes _____ No _____