



Standard Consent Form

TO: Glenolden Animal Hospital: Dr. R. Rieder, Dr. Sprowls, Dr. Mayer, and/or Dr. St. John

Owner's Name: _____
Address: _____
Home Number and Name of person to reach _____
Telephone # _____ today between 8 AM-5 PM # _____

If your pet is hospitalized, name of individual family spokesperson for us to contact _____
ONLY this person will receive updates from our doctors and be contacted for decision making.

Name of Pet : _____ Sex: ()Male ()Neutered ()Female ()Spayed
Species: ()Dog ()Cat ()Other _____ Breed: _____

The above pet has received the following within the past 7 days (please be specific):
()Aspirin ()Rimadyl ()Metacam ()Antibiotic _____
()Other pain medication _____ ()Flea or Tick topical medication _____
()Vitamin or other supplement _____ ()Other _____
()NONE

Please list or describe any medical problems, illnesses or concerns that our doctors should be made aware:

As the owner or agent for the above-described animal and with the authority to execute this consent:
I HEREBY CONSENT AND AUTHORIZE THE FOLLOWING TESTS, PROCEDURES AND/OR OPERATIONS
(please list or describe or write "As Per Estimate" if you have received an estimate):

I understand that during the performance of the foregoing procedure(s) or operation(s), unforeseen conditions may be revealed that necessitate an extension of the foregoing procedure(s) or operation(s) than those set forth above. Therefore, I hereby consent to and authorize the performance of such procedure(s) or operation(s) as are necessary and desirable in the exercise of the veterinarian's professional judgment. I also authorize the use of appropriate anesthetics and other medications, and I understand that Hospital support personnel will be employed as deemed necessary by the veterinarian. I have been advised as to the nature of the procedures or operations. I have been able to ask questions and have been informed of the risks involved. I understand that anesthesia, sedation and/or surgery has inherent risks including death. Due to the nature of medicine, I also realize that results cannot be guaranteed.

PAYMENT POLICY - payment must be made in full BEFORE patient can be discharge from the hospital.
Before treatment is initiated or services are rendered, would you like a written estimate of cost? ()YES ()NO
I PLAN TO PAY BY: ()Cash ()Check ()Visa/MasterCard ()American Express ()Discover

Driver's license required if paying by check. # _____

I HAVE READ AND UNDERSTAND THIS AUTHORIZATION AND CONSENT.

X _____ Date _____

Signature of owner or agent

_____ Date _____

Employee Witness to above Signature