**Baze Animal Clinic**

1301 North Big Spring Street

Midland, Texas 79701

432-682-3524

**FELINE ANESTHESIA RELEASE**

**PLEASE PRINT**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Owner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Pet Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_Intact Male / Neutered Male / Intact Female / Spayed Female

Breed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Color/Markings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approximate Weight: \_\_\_\_\_\_\_\_\_

Is your pet on any medications? Yes No If Yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your pet had any allergic reaction to a vaccine, insect bite or any medication, in the past? Yes No

 If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What occurred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Be aware, there is an additional charge for performing a Spay while in heat or pregnant

In the past month, has your pet had any: coughing, sneezing, diarrhea, not eating, vomiting? Yes No

 If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What occurred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your pet have fleas, ticks, or mites? Yes No If Yes, have they been treated/when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note: During your pet’s stay, to avoid the spread of parasites (ticks, fleas, or other external parasites) your pet will be treated at your cost.**

**VACCINATIONS AND MICROCHIPS**

Has your pet been Microchipped? Yes No If Yes, Microchip #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your pet up-to-date on vaccinations? Yes No

 If Yes, last vaccination date: \_\_\_\_\_\_\_\_\_\_\_\_\_ City of Midland Tag #: \_\_\_\_\_\_\_\_\_\_\_

My pet is here for:

**Vaccinations: Rabies / Feline Respiratory Combo / Feline Leukemia**

**Place a Microchip**

**Spay or Neuter (circle one):** City of Midland Voucher Obtained: Yes No Voucher #: \_\_\_\_\_\_\_\_\_\_\_

 Eligible for Midland County Credit: Yes No

 (For Midland County Credit, owner must bring utility bill to prove residency,

 pet has/receives microchip and is up to date on vaccinations.)

**Tumor Removal: where on the body?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ sending off for analysis? Yes / No**

**Teeth Cleaning: Are we permitted to extract teeth at the doctor’s discretion: Yes / No**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pet Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Owner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

KENNEL #

**Best Contact Number to Call After Surgery Today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SURGICAL PROCEDURE CONSENT**

The last time my pet ate or drank was on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_ am/pm time.

My pet has had problems linked to surgical procedures (seizures, diarrhea, vomiting, etc)? Yes No

 If Yes, what occurred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREANESTHETIC BLOOD WORK IS REQUIRED FOR PETS OVER THE AGE OF 6 YEARS ($75 charge)

My pet is 6+ years old: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_ If NO, would you like bloodwork? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

We offer blood testing for exposure to Feline Leukemia and Feline Immunodeficiency Virus ($35).

Please perform this test: Yes / No

**RISKS**

I understand receiving anesthesia involves some risk to my pet and I agree I will not hold any person associated with Baze Animal Clinic, Baze Veterinary, or Veterinary Practice Management Services (to include assistants, veterinarians or management) liable or responsible in any manner for the injury, escape, or death of my pet, in connection with the procedure. I will discuss any questions or concerns I have with my veterinarian before the procedure. I give my consent for this procedure and agree to pay in full for the services rendered.

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

Signature of Owner Date

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

Witness/Staff Signature Date

To Be Filled Out By Veterinarian Clinic Staff

Temperature of Pet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight of Pet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIAGNOSIS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Services Rendered:

* Vaccinations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_

 Microchip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_

 Dental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_

 Procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_

 Lab Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_

 City of Midland Voucher (Rabies #\_\_\_\_\_\_\_\_\_) $ \_-\_\_\_\_\_\_\_

 Midland County Credit (Rabies #\_\_\_\_\_\_\_\_\_\_) $ \_-\_\_\_\_\_\_\_

 ( Microchip #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Other Discount $ \_-\_\_\_\_\_\_\_

 **TOTAL DUE: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**