

Arrive for admission between 8:00am and 8:30 am on _____.

Fasting instructions: NO FOOD after 8:00 PM the night prior to anesthesia. Access to water is acceptable.

Please Note: If your pet has external parasites on admission, treatment will be applied at your expense.

Date: _____

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

Procedure(s) Scheduled for Today:

- | | |
|---|---|
| <input type="checkbox"/> OHE-Spay | <input type="checkbox"/> Laparotomy (Exploratory) |
| <input type="checkbox"/> Castration | <input type="checkbox"/> Deep ear cleaning +/- Myringotomy |
| <input type="checkbox"/> Declaw (LASER Only) | <input type="checkbox"/> Cystotomy (Urinary bladder surgery) |
| <input type="checkbox"/> Biopsy (complete the locator map) | <input type="checkbox"/> Extract retained deciduous tooth/teeth |
| <input type="checkbox"/> Excision "lump removal" (complete locator map) | <input type="checkbox"/> Specialist: _____ |
| | <input type="checkbox"/> Other: _____ |

Pre-anesthetic blood testing: \$107.32 Accept Decline

This test can help reveal hidden problems, which could alter or even prohibit anesthesia.

Blood clotting test: \$65.89 Accept Decline

Highly recommended before any invasive surgical procedure. Blood clotting disorders are uncommon, but this test can detect abnormalities before pursuing surgery.

Electrocardiogram Screen (ECG): \$52.00 Accept Decline

This screen can help detect abnormal electrical impulses and/or changes in the size of the heart.

Other Services Requested:

- Express Anal Sacs Nail Trim Clean Ears Microchip

What do you feed your pet? _____

When did your pet last eat? _____

When did your pet last drink? _____

Is your pet on heartworm preventative? No Yes If yes, what? _____

Is your pet on flea/tick medication? No Yes If yes, what? _____

Is your pet on any other medication(s)? No Yes If yes, dosage and time last given: _____

Permission for Diagnostics and Treatment. Please read before signing.

If we find the need for diagnostic labwork or x-rays, would you like us to:

- Perform the procedures if below \$ _____ Contact you with an estimate

If your pet requires surgical/anesthetic procedures, would you like us to:

- Perform the procedures Contact you with an estimate

I permit DeSoto Animal Clinic to treat my pet within the above guidelines.

Signature: _____ Date: _____

Home #: _____ Cell #: _____ Work #: _____

Please indicate your preferred contact number: _____

- Estimate Provided to Client _____ Employee Initial