

Abbey Animal Hospital

Caring. Helping. Healing.



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DR. SCOTT HOBSON
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DR. DIANA D'AMICO

AUTHORIZATION TO PERFORM MEDICAL AND/OR SURGICAL TREATMENT

Date: _____

I, the undersigned, owner of the admitted patient, hereby authorize **ABBEY ANIMAL HOSPITAL** to administer such treatment necessary, and to perform medical procedures and additional procedures as are therapeutically and/or diagnostically necessary as indicated by findings during medical evaluation. I also understand that unforeseen conditions may be revealed during the examination, which, in the opinion of the attending veterinarian, requires more extensive or different procedures or treatments. I understand that reasonable efforts will be made to contact me to explain these procedures and treatments and obtain my instructions regarding them. However, if the efforts are unsuccessful, I authorize the performance of any procedures or treatments that are necessary in the professional opinion of the attending veterinarian.

I also understand that if additional time or procedures are required, the final charge will be adjusted accordingly. I hereby certify that I have read and fully understand the above "AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT". I also understand that no guarantee has been made regarding the results that may be obtained. Further, I assume financial responsibility for all charges incurred to the patient.

PROCEDURE: _____

OWNER'S NAME: _____

ADDRESS: _____

CONTACT TELEPHONE NUMBER: _____ ALTERNATIVE TELEPHONE NUMBER: _____

ANIMAL'S NAME: _____ SPECIES (CIRCLE ONE): CAT / DOG / RABBIT / OTHER _____

SEX: _____ BREED (TYPE): _____ COLOR: _____ AGE: _____

ELECTIVE PROCEDURES TO BE PROVIDED AT AN ADDITIONAL COST:

- | | |
|--|--------------------|
| 1) Microchip Identification | YES _____ NO _____ |
| 2) Post-Surgical Pain Relief Medication
(Included with all reproductive surgeries) | YES _____ NO _____ |
| 3) Pre-Anaesthetic Blood Screen | YES _____ NO _____ |
| 4) Removal of Retained Deciduous (baby) Teeth | YES _____ NO _____ |
| 5) Hind Dewclaw Removal (dogs) | YES _____ NO _____ |
| 6) Umbilical Hernia Repair | YES _____ NO _____ |
| 7) Additional Extractions (dental procedures only) | YES _____ NO _____ |
| 8) Lacrimal (tear) Duct Flush | YES _____ NO _____ |
| 9) Other | YES _____ NO _____ |

PAYMENT IN FULL IS DUE AT TIME OF PICK-UP.

We accept the following means of payment. Please indicate which you will be using for today's procedure.

VISA MASTERCARD INTERAC CASH

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE.

DEPOSIT REQUESTED _____

(SIGNATURE OF OWNER OR AUTHORIZED AGENT)