FOX RUN EQUINE CENTER

798 Fox Road
Apollo, PA 15613
Phone (724) 727-3481
Fax (724) 727-7436

Brian Burks, D.V.M.,
Diplomate A.B.V.P.

John M. Leonard, V.M.D.

Consent for Anesthesia
Consent for Surgery

Date:________________________

I am the owner or agent for the above described animal and have the authority to execute consent for the surgical/medical procedure known as ________________________________ (name of procedure/operation). The reasons why this operation/procedure is necessary, its advantages, possible complications, and possible alternative modes of treatment have been discussed with me.

With full understanding of the above, the undersigned owner/agent authorizes ____________________ (name of veterinarian) to perform, under any anesthetic deemed advisable, said operation/procedure. I understand that further procedures may be therapeutically necessary based on findings during the operation/procedure, I consent to those procedures, their additional cost, and any unexpected lifesaving emergency care deemed necessary by the attending veterinarian.

I understand that risks and potential complications exist with anesthesia and surgery. These include, but are not limited to:

- abnormal reaction to anesthetic agents, self inflicted injury during anesthesia recovery (i.e., fractured legs, head trauma), muscle and nerve damage, dehiscence of incision, colic, post-operative infection, equipment failure, and death.

- Surgically removed tissues will be processed according to normal hospital policy to establish an accurate diagnosis.

If applicable, the insurance company has been notified and permission to proceed was received on ______________________ (date).

I acknowledge and understand that the procedure, its consequences, and subsequent risks have been explained to me, and I have addressed any questions or concerns I may have. I also realize that results cannot be guaranteed.

I have read and understand this authorization and consent.

____________________________________ ____________________________________
(Owner/Agent of animal) (Witness/Attending Clinician)

FOX RUN EQUINE CENTER

798 Fox Road
Apollo, PA 15613
Phone (724) 727-3481
Fax (724) 727-7436

Brian S. Burks, D.V.M.,
Diplomate A.B.V.P.

John M. Leonard, V.M.D.

Owner: ____ **Date**_____/_____/_____

Home Phone: ____________________________ **Cell Phone:**____________________**Email:**______________________

Address: ____**City:**_____________**State:**________**Zip:**______________

****

Patient:______________________________ **Age:**__________ **Breed:**__________**Gender:**_______ **Color:**________

****

Reason for visit: ____

History of Present Illness: ____

____

Past History: What Happened and When

- **Medical:**____
- **Surgical:**____
- **Trauma:**____

Vaccinations:____

Coggins:____

Deworming Program:____

Current Diet:____

Is Your Horse Covered By Insurance? No_____ **Yes**_____

Insurance Company and Policy Number:____

Mares: Currently (circle) pregnant or nursing? Days of gestation:__________________ **Age of foal:**_____________

Currently Eating? Yes_____ **No**_____ **Eating normally? Yes**_____ **No**_____

Describe Eating:____

____

Additional Information:____

____

____

____

____

FOX RUN EQUINE CENTER

798 Fox Road
Apollo, PA 15613
Phone (724) 727-3481
Fax (724) 727-7436

Brian S. Burks, D.V.M.,
Diplomate A.B.V.P.

John M. Leonard, V.M.D.

Clinician:______________________________ Admit Date:_________ Time:________

Owner Name:____

Animal Name:____________________ Species:______________ Breed:______________________

Consent for Treatment and Financial Obligation

Please read the following statements and consents regarding your animal while it is under the care of personnel at Fox Run Equine Center and your financial obligation as the result of this care. If you have any questions, please have these clarified before your animal is examined.

I authorize Fox Run Equine Center to perform medical and diagnostic procedures on the animal identified in this record as required for diagnosis and treatment. I understand that I can refuse or terminate procedures at any time by contacting the attending veterinarian. Emergency procedures may be needed in life saving situations and may be carried out before you can be contacted. You must instruct the attending veterinarian if there are financial or medical limitations to emergency care.

Practical and reasonable procedures are followed by Fox Run Equine Center personnel to reduce the chances of injury and acquired sickness occurring on out patients. However, new problems may be found and/or complications may arise during hospitalization and in the process of carrying out diagnostic and treatment procedures. The risk of infection is higher in a hospital environment than in an ordinary environment. Very young and/or sick animals are more susceptible to infection carried by people, other animals, and the environment. The Hospital will not assume the cost of treatment for such infection or injury sustained by its patients. As owner or authorized agent of the admitted patient, I authorize Fox Run Equine Center to administer agreed on diagnostic and treatment procedures and emergency treatment as considered necessary. I understand that it is my responsibility to inform the attending veterinarian about any treatment or diagnostic test that I do not want my animal to receive. In the event I sell this animal to another owner, I authorize the release of medical information to the new owner. An animal left at the Hospital over five (5) working days, without communication from the owner/agent, beyond the recommended dismissal date is considered abandoned. Every effort will be made to contact the owner during this period of time. At this point it will become the property of Fox Run Equine Center. The Hospital considers the identification of a referring veterinarian to imply that you authorize a release of medical record information to that veterinarian.

I hereby acknowledge that I have read the above and understand the cited risks. Risks of specific treatment and diagnostic procedures will be explained by attending veterinarians and specific consent forms will be needed. I also understand that no guarantee or assurance can be made to me as to the results that may be obtained.____________(Initial)

As agent or owner, I understand that the owner is financially responsible to Fox Run Equine Center for all applicable charges relating to this animal. It is the owner's obligation to inquire about all costs of patient care and to maintain knowledge of the status of the financial obligation to the Hospital. __________________(Initial)

Payment for hospital services is due in full at the time of dismissal._______________(Initial)

Owner's Signature: ______________________________________ Date: _______________

Agent's Signature: ______________________________________ Date: _______________