



Rock Creek Veterinary Hospital
 1445 NW 185th
 Aloha, Oregon 97006
 (503) 645-4458

Medical Treatment Consent Form

Date: _____

Client ID: _____ Patient ID: _____
 Client Name: _____ Patient Name: _____
 Address: _____ Species: _____
 _____ Breed: _____
 _____ Sex: _____
 Phone: _____ Color: _____
 Email Address: _____ Date of Birth: _____

Medical Procedure (s): _____
 If requested, we would be glad to provide an estimated cost. *This is only an estimate.* Some surgical procedures may require more services than originally anticipated (i.e. labwork, urinalysis, radiographs, etc.) Please ask for an estimate at time of check-in or request a phone call from the Dr. prior to starting the procedure.

Contact Information: *It is imperative that we have phone numbers where you can be reached immediately.*
 (We do not call pagers)

Phone Number:	Name	Number	Please circle
_____	_____	_____	Hm - Wk - Cell
_____	_____	_____	Hm - Wk - Cell
_____	_____	_____	Hm - Wk - Cell

*If you can not be reached immediately when a decision must be made for the care of your pet do wish us to:
 _____ **Proceed** with the care of your pet at the discretion of the attending Dr.
 _____ **Do not proceed** without speaking to you first. You understand that this may mean not performing a procedure or not completing a procedure until you can be reached and may cause your pet prolonged or additional anesthesia.

- Has your pet eaten today? NO YES If yes, what time? _____
- Are there any special conditions we should be aware of? NO YES
 If yes, please describe: _____

Please indicate if you would also like any of the following services:

___Yes ___No Fecal Examination ___Yes ___No Heartworm Testing
 ___Yes ___No Home Again Microchip ___Yes ___No Check/ Express Anal Glands
 ___Yes ___No Nail Trim (complimentary for all surgical patients)
 ___Yes ___No Vaccinations (Patient must be current to be hospitalized)

I authorize Rock Creek Veterinary Hospital to administer medical/surgical treatment as necessary. I also consent to the administration of such anesthetics as necessary. I certify that I have read and fully understand the above authorization for medical/surgical treatment. I understand the advantages and possible alternatives. I also certify that no guarantee or assurance has been made as to the results that may be obtained. Further, I understand that all fees are due in full when services are complete and I agree to pay those fees. I also understand that I am responsible for all finance, collections, and attorney fees incurred if I do not pay these charges.

Signature of Owner or authorized Agent: _____