CHS
Cascades Humane Society

DATE OF SURGERY

Outpatient Surgery Form

Your first name | **Your last name** | Your pet's name | Pet's Age

☐ Cat ☐ Dog | ☐ Male ☐ Female | Pet's color(s) **& Breed** | **How did you hear about us?**

Address | **City** | **State** | **ZIP**

Phone Number (where we can reach you TODAY) | **Alternate Phone Number** - - | **Email Address**

It is important for you to understand that the risk of injury or death, although extremely low, is always present just as it is for humans who undergo surgery. Carefully read and understand the following before signing your name.

I, acting as owner or agent of the pet named above, hereby request and authorize the Cascades Humane Society, through whomever veterinarians they may designate, to perform an operation for sexual sterilization of the animal named on the above portion of this form.

INITIAL BELOW

____ I understand that the operation presents some hazards and that injury to or death of such an animal may conceivably result, for there is some risk in the procedure and the use of anesthetics and drugs in providing this service. Cascades Humane Society cannot provide or pay for any aftercare in the event of any complications.

____ I certify that my animal is in good health and has had no food since 12:00 midnight.

____ I understand that Cascades Humane Society has the right to refuse service to any animal to whom surgery is deemed a health risk and that my animal may be exposed to other animals with unknown health histories with the potential for infectious disease.

____ I understand some factors significantly increase surgical risk, including but not limited to, pregnancy, heat, obesity, age and diseases such as Feline Immunodeficiency Virus, Feline Leukemia, and heartworms, and that if my animal is pregnant, the pregnancy will be terminated at surgery.

In the past week has your animal displayed any of the following (circle all that apply): Diarrhea Sneezing Coughing Change in Activity Level

Owners of pets left after the agreed date shall be charged a boarding fee of no less than $35 per night. **Owners are fully responsible for the ongoing care of their animal after it is discharged from the care of Cascades Humane Society.**

I hereby release the Cascades Humane Society, all veterinarians, assistants, volunteers, directors, and employees from any and all claims arising out of or connected with the performance of this procedure or any adverse reactions from vaccinations. I agree that I have not and will not claim any right of compensation from them, or any of them, or file action by reason of such sterilization or attempted sterilization of such animal or any consequences related thereto. Owner/ agent hereby agrees to indemnify and hold Cascades Humane Society harmless for any damages caused during the transportation of the animal, or for any damages caused by any unforeseeable events including fire, vandalism, burglary, extreme weather, natural disasters or acts of God.

Requested Additional Services

☐ Rabies Vaccine (1-yr) $15*

☐ Felv/FIV or HeartwormTest $30

☐ **I would like to donate to help keep surgeries affordable and save lives in my community $_____**

SIGNATURE

DATE

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Patient History and Pre-Surgical Exam

Date: _____ Patient Age/Sex: _____

Client Name: _____ Patient Name: _____

Description: _____

_____

How did you obtain this animal? _____ How long have you had this animal? _____

Has your pet ever been seen by a veterinarian? _____

Name of Vet? _____

Date of last exam? _____ Reason for exam? _____

Has this animal ever had vaccinations? _____

Did your pet have any problems from vaccines? _____

Has your pet had any testing/bloodwork? (Dogs) Heartworm test _____ (Cats) FeLV/FIV test _____

When and where was the bloodwork done? _____

Has your pet ever been hospitalized? _____ If so, when/why: _____

Is your pet on any medications? _____ Parasite prevention (includes heartworm)? _____

If so, please explain: _____

Has this animal ever had any seizures? _____ If yes, please explain: _____

Surgical Procedure _____

Date: _____ Weight: _____ Any abnormalities: _____

Drugs/Medication: _____

_____

Doctor's Notes: _____

_____

_____

Dr Signature: _____ Date: _____