

DANADA VETERINARY HOSPITAL, P.C.  
10 WEST LOOP RD.  
WHEATON, IL 60189

**SURGERY RELEASE FORM**

DATE: \_\_\_\_\_

**ALL PETS MUST BE CURRENT ON VACCINATIONS AND FREE OF PARASITES WHILE HOSPITALIZED.  
ANY VACCINATIONS THAT ARE DUE MUST BE DONE AT LEAST 7 DAYS PRIOR TO  
SURGERY/MEDICAL TESTING AND PARASITES TREATED AT THE OWNER'S EXPENSE.**

I hereby consent and authorize Danada Veterinary Hospital/ Drs. Dane, Wallach, Kelly, Hiller, Norberg, and Berley to receive, prescribe for, treat or operate upon \_\_\_\_\_ owned by \_\_\_\_\_.

Danada Veterinary Hospital is to use all reasonable precautions against injury, escape or death of the animal(s), but will not be held responsible in any such event. I understand Danada Veterinary Hospital is not a 24-hour care facility and hospital personnel may not be present outside normal business hours.

I understand that during the performance of any procedure or operation, unforeseen conditions may necessitate an extension of, or addition of, a procedure or operation. Therefore, I consent to and authorize the performance of such as are deemed necessary by the veterinarian's professional judgment. I understand there are risks involved in putting any animal under anesthesia and I realize that results cannot be guaranteed. I also authorize the use of appropriate anesthetics and other medications and I understand that the hospital support personnel will be employed as deemed necessary by the veterinarian.

**SERVICES REQUESTED:**

**SURGERY** \_\_\_\_\_ (pre-surgical blood panel, nail trim and IV fluids included)  
Spay \_\_\_\_\_ Neuter \_\_\_\_\_ Declaw (2 or 4) \_\_\_\_\_ Dentistry/tooth extraction \_\_\_\_\_  
Growth Removal \_\_\_\_\_ Location of growth \_\_\_\_\_ Other \_\_\_\_\_

**DIET:** dry \_\_\_\_\_ canned \_\_\_\_\_ other \_\_\_\_\_  
(circle) am pm free feed am pm free feed

**VACCINES NEEDED: Will be confirmed at check in**

Distemper (1 yr / 3 yr) \_\_\_\_\_ Rabies \_\_\_\_\_ Bordetella (SQ / IN) \_\_\_\_\_ Stool Check \_\_\_\_\_  
Heartworm test \_\_\_\_\_ Lepto \_\_\_\_\_ Lyme \_\_\_\_\_ Chlamydia \_\_\_\_\_ Leukemia \_\_\_\_\_

Microchip Implantation and Home Again Registration (\$41.99) \_\_\_\_\_

**PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.  
PATIENTS WILL NOT BE RELEASED WITHOUT PAYMENT IN FULL.**

CONTACT PHONE: Day \_\_\_\_\_ Night \_\_\_\_\_

I have read, understand and consent to the above: \_\_\_\_\_  
owner/representative's signature