WEST BRANCH ANIMAL CLINIC

508 N. 4TH ST.

WEST BRANCH, IA 52358

AUTHORIZATION FOR TREATMENT

I authorize the veterinarians of the **West Branch Animal Clinic** to perform such diagnostic, therapeutic and surgical procedures as deemed advisable for my pet. The nature of the procedure has been explained to me and no guarantee has been made as to the result or cure. I fully understand that this procedure, as with any other anesthetic procedure has an inherent risk. I agree not to hold the **West Branch Animal Clinic** liable in the event that the anticipated results are not achieved.

SURGICAL PROCEDURE:____

CLIENT NAME:____

VETERINARIAN:____

PET'S NAME:____

PREOPERATORY BLOOD CHEMISTRY:

I authorize the West Branch Animal Clinic to perform pre-operatory blood chemistry.

Yes______ No______ Dr's Discretion________

Owner or Responsible Party

(signature)____Date____________________

(print)______________________________Cell phone number____________________