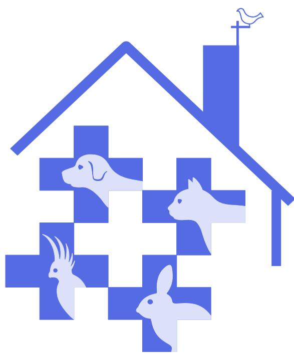

CASTRO VALLEY COMPANION ANIMAL HOSPITAL
2509 Lessley Ave.
Castro Valley, CA 94546
510-582-6311
www.cvcah.com

Surgical Release Form

Owner's Name: ______________________ **B-day:** __________ **Date:** __________

Pet's Name: ______________________ **Species:** ______________ **Breed:** ______________

Age: ______________ **Sex:** __________ **Description:** ______________________

PHONE NUMBER(S) WHERE YOU CAN BE REACHED TODAY

Cell: ______________ **Work:** ______________ **Other:** ______________

E-Mail: ______________________________

IN CASE WE ARE UNABLE TO REACH YOU, PLEASE GIVE AN EMERGENCY CONTACT:

Name: ______________________ **Phone:** ______________

Procedure(s) to be performed today: ______________________________

Pet Health Insurance Carrier: ______________________________

Is your pet sick? **Yes ( )** **No ( )** *(If yes, please fill out a separate Drop off Form from the receptionist)*

When was the last time your pet had anything to eat? __________ **Last time they had anything to drink?** __________

Current Diet: ______________ **# of feedings:** __________ **Treat/Other foods:** __________

Is your pet currently on any medications? **Yes ( )** **No ( )**
If yes, please fill out section below:

Medication: ______________ **Dosage:** __________ **Frequency:** __________ **Last given:** __________
Medication: ______________ **Dosage:** __________ **Frequency:** __________ **Last given:** __________
Medication: ______________ **Dosage:** __________ **Frequency:** __________ **Last given:** __________
Medication: ______________ **Dosage:** __________ **Frequency:** __________ **Last given:** __________

Would you like any other additional services? *(Please circle)* **Heartworm Testing** **Acutherapy** **Ear Cleaning** **Nail Trim** **Vaccination Update** **Fecal** **Microchipping** **Anal gland Expression**

I, the undersigned, certify that I am the owner or duly authorized agent for the owner of the pet described above and accept full financial responsibility. PROFESSIONAL FEES ARE DUE AT THE TIME OF PATIENT RELEASE.
I authorized Castro Valley Companion Animal Hospital (CVCAH), its agents and representatives to perform surgical procedures and pre-operative screening described above and to perform any other procedure that, at the doctor's discretion, may be useful to promote the health of my pet. I have been advised as to the nature of the surgery and/or procedures and the risks involved. I acknowledge that results cannot be guaranteed.
I am aware all reasonable care will be taken by CVCAH for the safe treatment and return of my pet. I release Castro Valley Companion Animal Hospital, Rene` C. Gandolfi, DVM, CVCAH agents and representatives from any and all liability. All pets hospitalized must be current on all vaccinations. If documentation cannot be provided or verified, I understand my pet will be vaccinated at the owner's expense. Any pet brought into the hospital with internal or external parasites, will be treated at the owner's expense.

I have read and understand this authorization and consent.

Signature of Owner/Agent: ______________________________ **Date:** ______________

Witness (Staff): ______________________________ **Date:** ______________