

# East County Large Animal Practice

10312 Quail Canyon Rd, El Cajon CA 92021

619-561-4661

## Consent to Treat

Date: \_\_\_\_\_

Owner's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

### Payment Information

Credit Card #: \_\_\_\_\_ Exp Date: \_\_\_\_\_ V Code: \_\_\_\_\_

Cash or Check Deposit Amount: \_\_\_\_\_

### Animal Information

Name: \_\_\_\_\_ Breed: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Normal Diet (for horses staying at facility)

AM: \_\_\_\_\_ PM: \_\_\_\_\_

Are you providing feed: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Procedure (s) to be performed: \_\_\_\_\_

By signing below, I consent to the performance of the above procedures on the above listed patient. I further consent to the administration of restraint such as anesthesia and administration of drugs and other procedures as may be considered necessary or desirable in the judgment of the admitting veterinarian.

I also consent to the taking of any photographs and/or videos in the course of the treatment for the purpose of advancing veterinary medical knowledge.

The risks involved in performance of the above procedure(s) have been explained to me in detail and I fully understand them.

Admitting Veterinarian: \_\_\_\_\_ Date: \_\_\_\_\_

Owner/Agent: \_\_\_\_\_ Date: \_\_\_\_\_