



Authorization for C.O.H.A.T.

Date: _____, 20__

Client Name: _____ Pet's Name: _____

Breed: _____ Age: _____ or DOB: _____ Sex: M / F / Male Castrated / Female Spayed

I, the undersigned owner or agent of the owner of the pet identified above, certify that I **am / am not** (circle one) eighteen years of age or over and authorize the veterinarian(s) at Pine Creek Veterinary Hospital to perform the C.O.H.A.T. procedure.

Animal dentistry is an important component of your pets overall health and well-being. The nature of animal (and human) dentistry makes it very difficult to accurately estimate what Dog test patient will require until we have your pet under anesthesia and are able to properly assess Dog test patient's teeth, gum health, gingival pockets and underlying bone structure.

I understand the veterinarian(s) at Pine Creek Veterinary Hospital **will perform full mouth dental radiographs of Dog test patient's teeth today to diagnose Dog test patient's oral health status and to provide a complete picture of their periodontal disease. I understand the doctor will then call me at the numbers provided below to discuss the best treatment plan. I further understand *the doctors will NOT perform any extractions nor periodontal work WITHOUT my permission.***

I understand that the doctor will make every attempt to reach me; however, **if they are unable to reach me and they do not hear back from me within 20 minutes, they will NOT perform any further therapy and will recover my pet.**

I understand that my pet *may experience unforeseen complications* associated with general anesthesia, such as, low blood pressure, nausea, aggitation or dysphoria (a state of unease) upon recovery. **I authorize the doctors and staff at Pine Creek Veterinary Hospital to treat my pet and administer medication as they deem appropriate for my pet's immediate medical and surgical needs.** I understand the team at PCVH will reach out to me to discuss any necessary medications as soon as possible; however, not at the expense of my pet's comfort and immediate medical needs.

Additional Procedures: _____.

I agree to assume financial responsibility for ALL fees incurred for the above mentioned medical and/or surgical procedures, and provide payment via cash, credit card, or check at the time my pet is discharged from the hospital.

I have been advised of the nature of the C.O.H.A.T. procedure and the potential risks and benefits. While Pine Creek Veterinary Hospital provides the highest quality of anesthetic monitoring and surgical services, I understand that there are rare and unforeseen complications associated with any anesthetic or surgical procedure and do not hold the staff and doctors at Pine Creek Veterinary Hospital liable for these potential complications. I fully understand these risks and that the veterinarians and hospital staff will do everything they can to minimize such risks. I am aware that conditions which increase risk associated with sedation and anesthesia include: obesity, diabetes, infection, blunt trauma, kidney disease, heart disease, liver disease, cancer, endocrine disease, and extreme stress and anxiety. I understand that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before the procedure(s) is/are initiated.

Should unexpected life-saving emergency care be required and the hospital staff is unable to reach me, the staff **has / does not have** (circle one) my permission to provide such treatment and I agree to pay for such services.

I have read and fully understand the terms and conditions set forth above.

Signature of Owner or Agent Date

BEST phone number: (719) 955-0966 OR _____

My preferred method of communications is (circle): PHONE TEXT E-mail

Staff Only: DISCHARGE: I, the owner, have received discharge instructions _____ (initials) **Staff initials** _____