

Columbus Animal Hospital

2278 39th Ave Columbus NE 68601
(402) 563-4151

ANESTHESIA / PROCEDURE RELEASE FORM

Owner: _____ Phone #: (____) _____

Address: _____ City/State : _____

e-mail: _____

Patient's Name: _____ dog / cat / other (specify) _____

Breed: _____ Sex: _____ Age: _____

Color and/or Markings: _____

I have signed below as the authorized owner or custodian of the animal described above, and hereby give the Doctors at **COLUMBUS ANIMAL HOSPITAL** permission to use anesthesia on this animal. I understand that a certain amount of risk is involved in this anesthetic and surgical/medical procedure. To help insure my pet comes home clean and completely recovered from anesthetic, I understand it will be hospitalized overnight and available for pick-up after 11:00 am on the agreed upon pick-up day.

Signed _____
owner or custodian

_____ Date

Ann Kramer DVM

Stephanie Wesely DVM

Jim Kramer DVM

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