

VALLEY VETERINARY CLINIC  
DANIEL L. DEWEERT, DVM  
TERESA M. DEWEERT, DVM

AUTHORIZATION FOR GENERAL ANESTHESIA & SURGICAL PROCEDURES

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

PET'S NAME \_\_\_\_\_ SEX \_\_\_\_\_ SPECIES \_\_\_\_\_

DOB \_\_\_\_\_ SURGERY SCHEDULED \_\_\_\_\_

DAYTIME PHONE# \_\_\_\_\_ EVENING PHONE# \_\_\_\_\_

**\*WOULD YOU LIKE A TEXT MESSAGE WHEN SURGERY IS COMPLETE: \_\_\_\_\_**

**If yes, number you would like us to text to: \_\_\_\_\_**

I hereby authorize Dr. Daniel and/or Dr. Teresa DeWeert to perform surgery on my pet named above. I understand the risks associated with this procedure and of the anesthetic required to perform this procedure. All of my questions and concerns regarding this procedure have been answered.

I understand that I will assume the financial responsibility for the services rendered.

Date \_\_\_\_\_

Owner \_\_\_\_\_

Witness \_\_\_\_\_