AUGUSTA ANIMAL HOSPITAL
199 Redskins Lane
Augusta, WV 26704
304-496-7746

AUGUSTA
ANIMAL HOSPITAL

DROP OFF CONSENT FORM

Patient Name: _____ Owner Name: _____

Reason for Visit (vaccines, sick, etc): _____

Owner Contact Number: _____

Brief History of issues with pet or any concerns you may have:

_____
_____
_____

Duration of symptoms (if applicable): _____

If my pet is here for an illness or injury, and the doctor feels it is necessary for the diagnosis of my pet. I am authorizing the following:

- Radiographs **$263.00**
- Blood work **$140.00**

Is your pet on any medications? If so please list:

_____

Does your pet have any vaccinations that need updated at this time?
If so, please list which ones you would like administered during their visit today_____

I verify that I am the owner (or authorized agent for the owner) of the above-named pet. I understand that with admitting by pet for diagnostics or treatment I authorize the staff at Augusta Animal Hospital to administer such treatment and/or perform such diagnostics as deemed necessary. I understand that when anesthesia is necessary there are always risks, including death. By signing below, I authorize this treatment and accept all financial responsibility for this appointment.

Owner Signature: _____Date: _____