

## Spay/Neuter Disclaimer

Date: \_\_\_\_\_ Owner Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ ZIP \_\_\_\_\_ Email: \_\_\_\_\_

DOG Name: \_\_\_\_\_ Breed: \_\_\_\_\_ Color(s): \_\_\_\_\_ Age \_\_\_\_\_ Sex: M / F

The Maryland SPCA Spay/Neuter Clinic is a high volume spay/neuter clinic. The procedures performed here are for the purposes of spaying/neutering cats and dogs; **the Maryland SPCA Spay/Neuter Clinic is not a veterinary or emergency veterinary clinic.** If issues arise that are directly related to the pet's spay/neuter surgery, please contact the Maryland SPCA during our regular hours of operation weekdays from 7:30 am – 4:00 pm at 410-889-7729 or [fixem@mdspca.org](mailto:fixem@mdspca.org) . **If you feel you need EMERGENCY help, please go to the nearest animal emergency center.** If you seek medical care, please note that the Maryland SPCA is not financially responsible for your bills. The Maryland SPCA uses qualified staffing and approved materials and medications for all procedures performed. It is important that you understand that the risk of injury or death, although extremely low, is always present for surgery and anesthesia – just as it is for human beings.

### Carefully read and understand the following before signing your name.

I certify that I am the responsible party for the pet described above, and have the authority to grant consent for The Maryland SPCA to receive, prescribe for, treat and/or operate on the pet. I understand the surgery contemplated is a Spay/Neuter, and I authorize this surgery. I understand that The Maryland SPCA will use responsible precautions against injury, escape, or death of the pet; and I understand that some risks include (but are not limited to) anesthetic reactions, infection, opening of the incision, hemorrhage, or death. I understand that if my pet is brachycephalic that anesthetic risks increase. Severe brachycephalic patients may be denied surgery. I understand that the Maryland SPCA does not routinely perform bloodwork, pre-surgical X-rays, or place IV catheters thus problems not identifiable through a pre-surgical examination could exist that might increase surgical risk. I will notify the Maryland SPCA if my pet has a pre-existing condition. All attempts will be made to examine the above named pet prior to anesthesia. I understand that if my pet is fractious or unable to be examined, I consent for the Maryland SPCA to proceed with anesthesia and surgery without an exam. If veterinary staff deem my pet too unhealthy for surgery, The Maryland SPCA reserves the right to cancel or reschedule. If my pet is found to be pregnant, I authorize the Maryland SPCA to proceed with spay surgery. If my pet is found to be severely matted, the Maryland SPCA may shave my pet. I understand that the Maryland SPCA Spay/Neuter Clinic does not provide regular veterinary services. I also understand that The Maryland SPCA does not provide 24-hour pet supervision. Your pet will receive a small tattoo at the time of spay/neuter, in compliance with recommendations from the Association of Shelter Veterinarians. If proof of vaccines are not presented at time of appointment, my pet will receive a DHPP+LEPTO and a Rabies vaccine.

I hereby release The Maryland SPCA, the veterinarians, assistants, and all of its employees and members from any and all claims arising out of or connected with the performance of this operation procedure. I agree that I have not claimed nor will not claim any right to compensation from any of the aforementioned parties, or file action by reason of such sterilization or attempted sterilization of such pet or any consequences related. The Maryland SPCA shall not be held responsible for any illness or defects which may have or may develop as a result of the procedure, nor shall The Maryland SPCA be liable for any damage or injury to person or property which may be caused by the pet

I verify to the best of my knowledge that the pet named above is healthy and free of any pre-existing conditions that may further complicate the Spay/Neuter surgery and/or any treatments I have requested. \_\_\_\_\_ (Initial)

To the best of my knowledge my pet is between 8 weeks and 7 years of age. \_\_\_\_\_ (Initial)

If my pet is cryptorchid (retained testicle/s) or has an observed reducible umbilical hernia, I consent to a \$20 additional surgery fee. \_\_\_\_\_ (Initial)

If my pet is found to have any of the following (fleas, intestinal parasites on visual inspection, skin infection):

I consent to any treatments necessary \_\_\_\_\_ (initial)

OR

Please call me before any treatments \_\_\_\_\_ (initial)

Please initial if you would like these additional recommended services: Microchip (\$25) \_\_\_\_\_ Trazodone (Mild Sedative) (\$10) \_\_\_\_\_ Heartworm test (\$25) \_\_\_\_\_  
(Trazodone may be prescribed due to activity level the patient displays)

If the pet is not picked up at the agreed upon time of **4:00PM**, the pet will be held at The Maryland SPCA and boarding fees will apply. If the pet is not picked up within **72 hours** of the specified pick up time, the pet will be considered abandoned and I agree that The Maryland SPCA may make a final disposition of the pet in accordance with the rules of The Maryland SPCA. This may include, but is not limited to, placing the pet for adoption or humane euthanasia.

### WE DO NOT PROVIDE 24-HR STAFF SUPERVISION

I understand that vaccinations and other veterinary treatments can cause adverse reactions in some pets. I hereby release The Maryland SPCA, the veterinarians, assistants and all other employees from any and all claims arising out of or connected with these vaccines and/or treatments.

X \_\_\_\_\_ (Responsible Party)

By signing above I verify that I agree to all of the terms and conditions outlined within this disclaimer.

I would like to donate funds to The Maryland SPCA so they can help spay or neuter other pets in the community.

I am able to donate:  \$1  \$5  \$10  Other: \$ \_\_\_\_\_ Thank you for your donation!

Species: DOG Sex: M / F Pet Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Pet ID: \_\_\_\_\_

Rabies:  Da2PPV/L4:  Nail Trim: \_\_\_\_\_ ←-INIT. TATTOO:  Revolution:  (HW -) HW: + --

Microchip  #: \_\_\_\_\_ Client concerns/requests: \_\_\_\_\_

Examining Vet: \_\_\_\_\_

Please check if exam was performed post-sedation. Reason: \_\_\_\_\_

S: Admitted for elective spay/neuter surgery. Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Approx. Age: \_\_\_\_\_

O:

Ears/Eyes/Nose	N	ABN	Oral	N	ABN
Lymph Nodes	N	ABN	Integument	N	ABN
Pulmonary	N	ABN	Cardiac	N	ABN
Upper Airways	N	ABN	Abdomen	N	ABN
Neurological	N	ABN	Musculoskeletal	N	ABN
Uro-Genital	N	ABN	Hydration	N	ABN
Mucus Membranes	N	ABN	BCS (#/5):		

Weight: \_\_\_\_\_

TEMP #1: \_\_\_\_\_ Time: \_\_\_\_\_

TEMP #2: \_\_\_\_\_ Time: \_\_\_\_\_

TEMP #3: \_\_\_\_\_ Time: \_\_\_\_\_

A: Surgical anesthesia risk level (Please circle one): 1 2 3 4 5

Notes: \_\_\_\_\_

P: Approved for neuter/OHE? YES NO : \_\_\_\_\_

Anesthesia/Analgesia Drugs	Tech Init	Tech Init
Telazol: _____ IM IV	_____	Bupren. (0.____mg): _____ IM IV _____
Ketamine: _____ IM IV	_____	Morphine: _____ IM IV _____
Midazolam: _____ IM IV	_____	Ace: _____ IM IV _____
Propofol: _____ IM IV	_____	Butorphanol: _____ IM IV _____
TTDex: _____ IM	_____	Antisedan: _____ IM _____
Carprofen, Inj: _____ SQ	_____	

Surgery Type: Performed by (if other than examining veterinarian): \_\_\_\_\_ DVM

Spay:	Routine, In heat	Pedicles	Mod. Miller's Surgeon's	Single Double	MAS 3-0 2-0 0
	Postpartum, Lactating Y / N	Uterine body	Mod. Miller's Surgeon's Transfixing	Single Double	MAS 3-0 2-0 0
	Pregnant: # ___ fetuses- early, mid, late	Linea	Sim. Continuous Cruciates	N/A	MAS 3-0 2-0 0
Neuter:	Normal Castration Cryptorchid	Cords	Mod. Miller's Surgeon's Autoligated	Single Double	MAS 3-0 2-0 0
	Scrotal Inc Prescrotal Inc .	SQ/Intraderm	Simp. Continuous Buried Simple Interrupted	N/A	MAS 3-0 2-0 0

Maintained on Isoflurane Intubated:  ETT#: \_\_\_\_\_

Surgery Notes:

Prescribed:  Capstar  Revolution  Convenia \_\_\_\_\_ cc  Other: \_\_\_\_\_

Carprofen \_\_\_\_\_ mg PO every 24 hours x \_\_\_\_\_ days. Next dose due \_\_\_\_\_

Trazodone \_\_\_\_\_ mg PO every 12 hours x \_\_\_\_\_ days. Next dose due \_\_\_\_\_