The Equine Podiatry & Lameness Centre

Dedicated expert care

EQUINE PROCEDURE / INTENSIVE CARE CONSENT & REFERRAL FORM

Please fill in required fields as marked * After filling in form - deliver or send to: **info@equinepodiatry.com.au**

ADMISSION AND CONSENT DETAILS

DATE: TIME: ☐ CLINIC ☐ ICU

OWNER

* NAME:

* ADDRESS:

* EMAIL:

* PHONE (W): PHONE (H):

* MOBILE:

* INSURANCE:

* PREFERRED COMMUNICATION METHOD:

* STRANGLES VACC: ☐ YES ☐ NO DATE:

* TETANUS VACC: ☐ YES ☐ NO DATE:

* WORM DRENCHED: ☐ YES ☐ NO DATE:

* TEETH: ☐ YES ☐ NO DATE:

HORSE

* NAME:

SIRE:

DAM:

BREED:

DISCIPLINE:

* DOB / YEAR: * SEX:

COLOUR : * BRANDS:

* MICROCHIP

EXAM REQUESTED BY:

*PROCEDURE REQUESTED:

* JOINT/HOOF SUPPLEMENT

* LAST SHOE/TRIM:

IS THIS HORSE FROM A HENDRA REGION? ☐ YES ☐ NO

* HENDRA VACC: ☐ YES ☐ NO DATE:

HISTORY / PREVIOUS DIAGNOSTICS / REASON FOR REFERRAL

MEDICATION: DAY OF ADMISSION

DRUG	DOSE	DOSE FREQUENCY

PODIATRY/LAMENESS CONSENT

I/We_____**(Owner/Agent)**

give consent for the above-described horse to have the above procedure undertaken by the Equine Podiatry Lameness Centre.

I/We acknowledge that no surgical, medical or anaesthetic treatment is without risk to the animal.

I/We acknowledge that EPLC has provided information regarding these risks on its website **www.equinepodiatry.com.au/risks** and that **I/we** understand the risks and have discussed any concerns with the veterinarian treating my/our horse.

I/We also acknowledge that complications may develop because of the procedure(s), which may incur additional fees. As owner I agree to pay all charges incurred on discharge of my animal. Or, in case of dispute, I as agent agree to pay these costs.

I/We acknowledge that post operative care may be required, and will be undertaken as deemed necessary by the attending Veterinarian.

I/We understand that veterinary data obtained while my horse is under veterinary care may be used for future scientific publications while ensuring that client confidentiality will be maintained.

HOSPITAL CARE CONSENT

I/We_____**(Owner/Agent)**

authorise The Equine Podiatry & Lameness Centre to administer Hospital Veterinary Treatment, Nursing Care and all diagnostic tests associated in the care of my animal.

I accept the estimated cost given for treatment and agree to pay all charges incurred on discharge of my animal.

* Signed: (OWNER / AGENT) * DATE

VERBAL CONSENT / AUTHORISATION ON BEHALF OF

SIGNED (OWNER / AGENT)

*** NOTE: NO SURGICAL PROCEDURES WILL TAKE PLACE WITHOUT A CONSENT SIGNATURE**

The Equine Podiatry & Lameness Centre | 14 Aberdeen Street Muswellbrook 2333 | PO Box 280 Scone 2337
T +61 2 6543 2000 | F +61 2 6543 2008 | info@equinepodiatry.com.au | www.equinepodiatry.com.au
The Equine Podiatry & Lameness Centre Pty Ltd | ABN 22 159 760 684

SCONE EQUINE GROUP
Veterinary Excellence