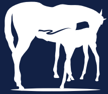

Avenel Equine Hospital

Dedicated expert care

CONSENT TO PERFORM A CASTRATION

Please fill in required fields as marked *

After filling in form - please print and fax or email to:
Avenel Reception: info@avenelequine.com.au
F +61 3 5796 2477

I (Name)____________________________of ____

Being the **OWNER/AGENT** of the below named horse and a person over the age of eighteen years, hereby authorise Avenel Equine Hospital and registered Veterinarian: ____________________________________to castrate the horse described below.

I, acknowedge that the horse named below **is/is not** currently insured.

I confirm that the insurance company or its agent (insert name of insurance company or its agent) ____________________________

has been notified of this procedure.

HORSE

* HORSE'S NAME OR DAM'S NAME AND COLT'S YEAR OF BIRTH ____________________________

* BRANDS: ____________________________

* BREED: ____________________________

* COLOUR: ____________________________

* AGE / DOB: ____________________________

* MICROCHIP: ____________________________

In consideration of the said Veterinarian providing the requisite treatment, I hereby agree to pay the prescribed fees, and further agree to indemnify him, his servants or agents, from loss or liability which they may incur as a result of any inaccuracy whether intended or otherwise in this my declaration.

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

I / We acknowledge that Avenel Equine Hospital has provided information regarding these risks on its website www.avenelequinehospital.com.au and that **I/ W**e understand the risks and have discussed any concerns with the veterinarian treating **my/our** horse.

____

* SIGNED * DATE

____

* WITNESS

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