KOWIE VETERINARY CLINIC

DR. L. FOURIE BVSc (PRET) *Veterinarian / Dierearts*

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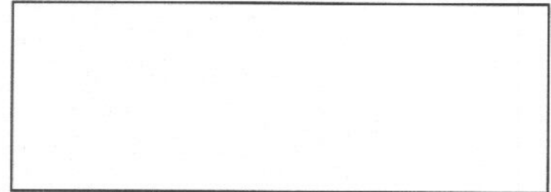

CLIENT DETAILS:

TITLE, FULL NAME & SURNAME: ....

ID \ PASSPORT NO: ....

POSTAL ADDRESS:...CODE:.....................

PHYSICAL ADDRESS: ....

TEL HOME: .... CELL: ....

TEL WORK: ....EMPLOYER ....

SPOUSE/PARTNER/ FRIEND ....NO: ....

PATIENTS DETAILS:

PATIENTS NAME: ....BREED ....

COLOUR .... GENDER: MALE / FEMALE

AGE \ DATE OF BIRTH .... STERILISED? YES / NO

DATE OF LAST VACCINATION (if applicable)..

ANY CONDITION VETERINARIAN HAS TO BE AWARE OF WHEN EXAMINING YOUR PET
....

IS YOUR PET ON A VETERINARY \ PRESCRIPTION DIET ....

ALL FEES TO BE PAID AFTER EACH CONSULTATION, PROCEDURE OR PURCHASE

I, the undersigned, hereby authorize the veterinarians and staff of this veterinary facility to perform any reasonable treatment, anaesthesia and\or surgery they may deem necessary, including any further measures as may be necessary during the course of the surgery and/or treatment of my animal. I am fully aware of the reasonable risks involved with this procedure and treatment and indemnify the veterinarians, staff and clinic against any claim for damages of whatsoever nature arising out of this procedure and treatment. I acknowledge that I am indebted to the above practice for veterinary treatment, services rendered and expenses incurred therewith and hereby render myself responsible for all costs thereof.

SIGNATURE:..DATE...