

Orange County Equine Veterinary Services

1633 East Fourth Street #170, CA 92701 Tel: (949) 472 0501 Fax: (949) 472 0654

Email: office@ocequine.com Website: www.ocequine.com

**** Please complete application in its entirety. Any section(s) left blank will be considered incomplete and may cause delay for services****

Emergency Treatment Authorization

In the event of a veterinary emergency involving your horse, every effort will be made to contact you regarding your horse's current condition. If however, decisions need to be made and procedures need to be performed in your absence, this form will act as a GUIDELINE for treatment of your horse. This release authorizes us to provide veterinary care in your absence and allows you to inform us of anything you do not authorize. It also gives you the opportunity to let us know who is authorized to make these important decisions on your behalf.

Your Information

Name _____

Address _____

Phone _____ (cell)

_____ (home)

_____ (work)

Email _____

Authorized Representatives

In my absence or the event that I cannot be reached, I allow the following people to make treatment decisions for the horses listed below.

1. Name _____ Relationship _____

Phone _____

2. Name _____ Relationship _____

Phone _____

3. Name _____ Relationship _____

Phone _____

4. Name _____ Relationship _____

Phone _____

~Please retain a copy of this for your records. Please also provide a copy to the stable where your horse resides, to your authorized representatives, and to Orange County Equine Veterinary Services~

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Horse Information

1. **Horse** (barn and show name) _____

Breed _____ Age _____ Sex _____

Boarding facility _____ Stall _____

Allergies or special concerns: _____

Monetary limit authorized for this horse: \$ _____

This horse IS _____ or IS NOT _____ insured (if yes, complete the following)

Type: _____ Surgical _____ Major Medical _____ Mortality _____ ColicCare/ EqCO

Company _____

Policy number _____ Expiration _____

Contact name and phone _____

2. **Horse** (barn and show name) _____

Breed _____ Age _____ Sex _____

Boarding facility _____ Stall _____

Allergies or special concerns: _____

Monetary limit authorized for this horse: \$ _____

This horse IS _____ or IS NOT _____ insured (if yes, complete the following)

Type: _____ Surgical _____ Major Medical _____ Mortality _____ ColicCare/ EqCO

Company _____

Policy number _____ Expiration _____

Contact name and phone _____

3. **Horse** (barn and show name) _____

Breed _____ Age _____ Sex _____

Boarding facility _____ Stall _____

Allergies or special concerns: _____

Monetary limit authorized for this horse: \$ _____

This horse IS _____ or IS NOT _____ insured (if yes, complete the following)

Type: _____ Surgical _____ Major Medical _____ Mortality _____ ColicCare/ EqCO

Company _____

Policy number _____ Expiration _____

Contact name and phone _____

****Owner's with more than 3 horses, please provide information on additional sheets.**

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Referral

I authorize the following horses to be referred to a secondary facility for emergency treatment or surgery if the doctors at Orange County Equine Veterinary Services, in their professional opinion, conclude that said horse may benefit from this emergency referral.

Colic is the most common emergency and the most common to be referred to a hospital, but I understand that other emergencies may need to be hospitalized and surgery may need to be performed. I understand that typical treatment costs for a medical colic starts from \$2,500-3,000 and treatment for a surgical colic starts from \$7,000-15,000, but costs can vary depending on the condition and hospital.

I authorize my horse(s) be sent to a referral hospital for (please indicate individual horse from list above, or state "ALL" for all horses included in list above):

Medical management only of a colic _____

Medical and/or surgical treatment of a colic _____

Monetary limit authorized for colic or other emergency _____

My referral facility of choice is listed below or I authorize the attending veterinarian to choose the hospital. _____ int

Preferred referral hospital name: _____

Phone _____

Address _____

* Please be aware that many referral facilities will not admit patients without a deposit or payment by you or your authorized agent. It is advisable to make arrangements with your authorized representative(s) in advance for this type of situation.

** Please note that if the horse is insured, the insurance company may require that surgery be attempted. Attempts to contact your insurance company will be made by the attending veterinarian and referral hospital.

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Transportation

In the event that my horse needs to be hospitalized, my preferred hauler(s) is

Name _____ Phone _____

Name _____ Phone _____

If these people are unavailable, the attending veterinarian will contact other shippers. I understand that payment for the hauler is my responsibility and not included in the monetary limit provided earlier.

Euthanasia

If the doctors of Orange County Equine Veterinary Services determine that my horse cannot be sufficiently treated and/or managed due to the severity of the condition or injury and/or financial constraints, I authorize them to euthanize the following horse(s) for humane reasons. Attempts will be made to contact your insurance company if applicable.

Payment

I will assume full responsibility for payment of all services rendered, including those by Orange County Equine Veterinary Services, the referral hospital, hauler, and livestock disposal.

Comments or Additional Instructions

Signature

I, (please print) _____, declare that I am the owner of the horse(s) described above. I have authority to execute this consent and am over the age of 18. I hereby authorize and direct the veterinarians of Orange County Equine Veterinary Services to perform the necessary procedures on my horse(s) as outlined above. I have thoroughly read and understand this consent form.

Signature _____

Date _____

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