

EMERGENCY TREATMENT CONSENT FORM

Dunbarton Equine, P.O. Box 599, 336 Federal Road, Brookfield, CT 06804

Phone: 203-775-5561, Fax: 203-775-0346

In the event of a medical emergency involving my horse(s), every effort should be made to contact me regarding my horse's current situation. In the case of a medical emergency where treatment must be provided immediately in order to preserve the health or life of my horse, and if neither I nor my designated caregiver can be reached, I authorize Dunbarton Equine, or another veterinarian affiliated with Dunbarton Equine, to employ the best veterinarian available to perform the necessary treatment to my horse. If decisions need to be made or procedures need to be performed in my absence, please use this form as a guideline.

I, _____
Name address Phone numbers

as the owner of the horses listed below,

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Which are stabled at _____ do
give my permission for the veterinarians of Dunbarton Equine to perform services on the
above named horse(s) in my absence.

I ___ would ___ would not want my horse referred to a secondary facility for emergency
treatment or surgery if the doctors at Dunbarton Equine, in their professional opinion,
conclude that my horse may benefit from this emergency referral.

The doctors may use their best judgment in determining if my horse can be saved within
a reasonable medical probability and financial practicality with a cost cap of
\$ _____.

I agree to assume full financial responsibility for these services. I understand that any
referral hospital will require a credit card with a deposit charged on that card at the time
of admittance. The following credit card is available for this situation

Name of Cardholder _____ Signature of Cardholder _____

Name of Card _____ Expiration Date _____

CV Code _____

Address where the credit card bill goes to _____