

Wolf Creek Equine Procedure at Facility

Date: _____ Drop Off Trailer-In /out

Owner (Billing) Name: _____ Driver Lic#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone (home): _____ Work Phone: _____ Cell Phone: _____

Contact Person: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____

Veterinarian Name: _____ Phone: _____

(If other than Wolfe Creek Equine)

Horse Information: Mare Stallion Foal Present Gelding

Horse's Name: _____ Age/Year: _____

Last Coggins: ____/____/____

Breed: _____ Color: _____ Markings/Tatoo/Brands: _____

Reason for visit: _____

Supplies arriving with animal: _____

I authorize Wolf Creek Equine (WCE) to perform procedures on the above noted horse as requested. WCE will follow practical and reasonable procedures to reduce the chance of injury or sickness in horses cared for or treated at our facility. I understand that emergency procedures may be needed in life saving situations (i.e. colic, laminitis, etc.) and that these procedures may need to be carried out before I can be contacted. WCE will make every effort to contact owners, trainer or agents prior to initiating any unauthorized diagnostic test or medical treatments related to an emergency situation. However, I authorize WCE to administer emergency treatments considered necessary.

In addition, I understand the inherent risk associated with equine general medicine. If I do not understand the risk or consequences, I acknowledge that it is my responsibility to ask and that WCE and its staff will explain the risk involved.

Owner/Agent Signature: _____ **Date:** _____