



# LONGFORD EQUINE CLINIC

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A Ballymore Stables P/L Enterprise • ABN 12 612 795 939  
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## CASTRATION AUTHORISATION

HORSE NAME.....  
IF un-named SIRE.....DAM.....  
COLOUR.....AGE.....SEX.....  
BREED.....MICROCHIP NO.....

BRANDS (NS) (OS)

OWNER(S).....  
ADDRESS.....  
CONTACT PHONE.....

I, .....on (insert date).....  
give authorization for Longford Equine Clinic to perform a surgical castration on the above horse. I am authorized to make this decision. I understand the horse will be given a general anaesthetic and that both this and the surgery incur certain risks. I accept these risks and acknowledge that I am responsible for any costs associated with this procedure.

SIGNED.....  
PRINT NAME.....

IF THE HORSE IS INSURED PLEASE NOTIFY YOUR INSURANCE COMPANY THIS PROCEDURE IS GOING TO BE PERFORMED.