



FELINE SURGERY AUTHORIZATION and MEDICAL RECORD

Surgery Date ____/____/____

Owner name: _____ Date: ____/____/____

Address: _____

City: _____ State: ____ Zip: _____ County: _____

Phone #: (____) _____ E-mail: _____

Cat's name: _____ Color: _____ DOB/Age: _____ Breed: _____ M/F: ____

Surgery:

____ Spay / Neuter
____ Ear Tip (*TNR/feral/Outdoor*) \$no charge
____ Dental (Average range \$150-200)
____ Other: _____

____ Additional oral pain meds \$10 (3 days)

Parasite Control:

____ Flea/Tick Control*
____ Broad spectrum Dewormer*
____ Heartworm Prevention*
____ Ear Clean / Mite Treatment \$15

____ **Buster Collar (E-Collar) \$10 - 15**

Organization Admin fee: \$ _____

Vaccination and Identification:

____ Rabies: 1-yr / 3yr \$10.00
____ FVRCP: Series / 1-yr / 3-yr \$15.00
____ Leukemia: Series / 1-yr / 3-yr \$20.00

***3-yr Rabies requires proof of previous vaccination
by a licensed veterinarian at time of intake***

____ **Microchip (24-Pet Watch) \$30.00**

Labwork:

____ Pre-Anesthesia Bloodwork (chem only) \$65
____ Junior Wellness Profile \$115.00
____ Senior Wellness Profile \$160.00
____ FeLV / FIV test: \$35.00
____ Fecal Exam \$40 ____ Diarrhea Panel: \$110

Additional Services requested: _____

I, the undersigned, certify that I am the owner, or authorized agent, of the animal described above. I authorize the doctor on duty and veterinary staff to perform the services listed above, including the administration of pain relief medications, sedatives, and anesthetics. I understand that, although rare, there are risks with any medical treatment, sedation and anesthetic procedure including drug/vaccine reactions, infection and death. I also understand that no guarantee of successful treatment can be made.

Signature of owner/agent: _____

For Clinic Use Only (do not write in fields below)

Wt. (lbs.): _____ Microchip: _____

Abnormal Findings: _____

Pre Med: _____

Induction: _____

Procedure Description: _____

Add'l Notes: _____



PATIENT HISTORY

Please fill in all information as completely as possible to
allow optimal care for your cat.

MUST BE FILLED THE DAY OF SURGERY, NOT BEFORE

Owners Name: _____ Patient's Name: _____

Telephone number where we can reach you today: (____) _____

How long have you owned this cat? _____

Where did you obtain this cat?

☐ Rescue ☐ Breeder ☐ Online ☐ Pet Store ☐ Stray ☐ Friend/Relative ☐ My cat's litter

Is your cat (circle one): ☐ Indoor only ☐ Outdoor Only ☐ Indoor/Outdoor

Has your cat displayed any of the following in the last 2 weeks: (check if yes)

☐ Sneezing ☐ Coughing ☐ Vomiting ☐ Diarrhea

Has your cat ever had a seizure? ☐ No ☐ Yes, explain: _____

Has your cat had any previous...:

...Illness, Injury or Previous Surgery? ☐ No ☐ Yes, please explain: _____

...Drug or vaccine reaction? ☐ No ☐ Yes, please explain: _____

Is your cat on any long-term medications? If so, list all _____

Has your cat been given any medications in the last 30 days? If so, list type and why it was given

Has your cat been treated for fleas/ticks? ☐ No ☐ Yes, what product was used? _____

Is your cat on monthly heartworm prevention? ☐ Yes ☐ No

If yes, what type? ☐ Heartguard. ☐ Revolution ☐ Nexgard Combo ☐ Other: _____

When did your cat last eat? _____

How did you hear about the Rascal Unit? _____

Do you have a regular veterinarian? ☐ Yes ☐ No

IF your cat is female: When was her last heat cycle? _____ ☐ Unsure ☐ Spayed

Has she had any litters? ☐ No. ☐ Yes, When? _____

Could your cat pregnant? ☐ Yes ☐ No