YOU ARE REGISTERING FOR A HSofMC SUBSIDIZED CLINIC BEING HELD IN MARENGO; PAYMENT AND REGISTRATION MUST BE SENT TO HSofMC PO BOX 298, MT. GILEAD, OH 43338 - CHECKS PAYABLE TO HSofMC

Rascal Unit

Surgery Date 2 / 19 / 2019

# FELINE SURGERY AUTHORIZATION and MEDICAL RECORD

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 (stray/feral) no additional charge
___ Dental (Average range $75 - $150)
___ Other: _____ $_____

**Parasite Control:**
___ Broad spectrum Dewormer*
___ Heartworm Prevention*
___ Flea/Tick Control*

* Price, type of product and availability varies. Please ask what is available at clinic for current information.

Organization Admin fee: $ _____

**Vaccination and Identification:**

| | |
|---|---|
| ___ Rabies | $7.00 |
| ___ FVRCP | $10.00 |
| ___ Leukemia | $15.00 |
| ___ Microchip | $25.00 |

**Labwork:**

| | |
|---|---|
| ___ Junior Wellness Profile | |
| ___ Senior Wellness Profile | |
| ___ FeLV/FIV Test | $25.00 |
| ___ Fecal Examination | $20.00 |
| ___ Pre-Anesthesia Bloodwork | $55 |
| ___ Buster Collar (E-Collar) | $10 |

**Additional Services requested or recommended:** _____

I, the undersigned, certify that I am the owner, or authorized agent, of the animal described above. I authorize the doctor on duty and assistants to perform the procedures listed above, including the administration of pain relief medications, sedatives and anesthetics. I understand that, although rare, there are risks with any medical treatment, surgical and anesthetic procedure including infection and death. I also understand that no guarantee of successful treatment can be made. If my cat is in need of post surgical care, I may contact the Rascal Animal Hospital in Dublin for a no-charge recheck at their location (fees for medications or procedures may apply) or seek another veterinary hospital at my own expense.

**Signature of owner/agent:** _____

***For Clinic Use Only (do not write below this line)***

Pre-op exam: Wt(lbs): _____ _____
Pre Med: _____
Induction: _____
Procedure Description: _____


Surgery Date ____/____/____

PATIENT CHECK-IN INFORMATION

**Please fill in all information as completely as possible to allow optimal care for your cat.**
**This form must be filled on the surgery day, not before**

Owners Name: _____Patient's Name: _____

Telephone number where we can reach you on day of surgery: (____) _____

How long have you owned this cat? _____

Where did you obtain this cat? _____

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

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? YesNo
If yes, explain: _____

Has your cat had any previous… (circle yes or no):
…Illness? Yes No If yes, please explain: _____
…Injuries? Yes No If yes, please explain: _____
…Surgery? Yes No If yes, please explain: _____
…Drug or vaccine **reaction**? Yes No If 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 month? If so, list type and why it was given
_____

**IF** your cat is female:
When was her last heat cycle? _____ Unsure
Has she had any litters? If so, when was the last time? Yes _____ No
Is your cat pregnant? (circle one) Yes No Could be

Has your cat been treated or dipped for fleas/ticks in the last month? Yes No
If yes, what product was used? _____

When was the last time your cat was FeLV/FIV tested? _____ Not tested Unsure if has been

Is your cat on monthly heartworm prevention? Yes No
If yes, what type? Heartguard Interceptor Revolution Other: _____

When did your cat last eat?_____

How did you hear about RASCAL? _____

Do you have a regular veterinarian? Yes No