____ of _____ total cats

Ear tip? Y or N

Prior Rabies Vaccine: Y or N
(attach proof)

DO NOT SEND FORM OR PAYMENT TO RASCAL!

$25 PER CAT!

RASCAL UNIT

Roaming Animal Sterilization Clinic at Low cost

Confirmation # ____
Arrival time: ______
Paid amount: ______

Surgery Date ___/___/___

FELINE SURGERY AUTHORIZATION and MEDICAL RECORD

Owner name: ____ Date: ____/____/____

Address: ____

City: __________________ State: ____ Zip: _____________ County: _______________________

Phone #: (____) _____________________ E-mail:__________________________________

Cat's name: _____________ Color: __________ Age/DOB: _________ Breed: ________ M/F: ____

Surgery:
___ Spay / Neuter
___ Dental (please ask for estimate)

Parasite Control:
___ Flea topical treatment*
___ Dewormer*
___ Ear clean / Ear mite treatment $5-10.00

* Please ask for price and product available at time of clinic

Clinic Admin fee if applicable $_______

Vaccination and Identification:
___ Rabies $7.00
___ FVRCP $10.00
___ Leukemia $13.00

___ Microchip $25.00

Labwork:
___ Felv/FIV/Heartworm $25.00
___ Fecal Examination*
___ Junior Wellness Pofile*
___ Senior Wellness Profile*

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 have been advised as to the nature of the procedure, the potential risks, and at-home care. I also understand that no guarantee of successful treatment can be made. If my pet is in need of post surgical care, I may contact RASCAL Unit 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

Pre-op exam: Wt(lbs): ______ T: _____ P: _____ R: ____
Pre Med:____
Induction:____
Procedure Description:____

____

____

***Mail payment and registration to: HSofMC POBox 298, Mt. Gilead, OH checks payable to HSofMC**