

# MEDICAL RECORD

Please fill out one form per cat.

Cat #

Name, phone # and demographics are required or services will be declined.

Today's contact (agent)		Phone		Clinic date / /	
Name on reservation, if different			Phone		
Name of owner/caretaker, if different			Phone		
Surgical waiver signed by: <input type="checkbox"/> Agent <input type="checkbox"/> Owner/caretaker		Cat arrived in: <input type="checkbox"/> Carrier <input type="checkbox"/> Trap		Cat should: <input type="checkbox"/> Remain in carrier/trap <input type="checkbox"/> Transfer to empty carrier	
Cat's gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Not sure		Coat length: <input type="checkbox"/> SH <input type="checkbox"/> MH <input type="checkbox"/> LH Color:		Cat is: <input type="checkbox"/> Tame <input type="checkbox"/> Untouchable <input type="checkbox"/> Not sure	
<input type="checkbox"/> <b>EAR TIP</b> ( <i>Identifies feral/free-roaming cats as being altered</i> ) – <i>or</i> –			<input type="checkbox"/> <b>TATTOO/No Ear Tip</b> ( <i>Tame cats</i> )		
<b>Please give this cat</b> ( <i>check all that apply</i> ): <input type="checkbox"/> <b>Rabies Vaccine</b> (Free to ear tip cats) — <b>\$5 at check-in</b> <input type="checkbox"/> <b>FVRCP Vaccine</b> (Distemper) — <b>\$5 at check-in</b> <input type="checkbox"/> <b>Flea Control</b> — <b>\$5 at check-in</b> <input type="checkbox"/> <b>Blood Draw</b> — <b>\$5 at check-in</b>			<b>DEMOGRAPHICS</b> ( <i>For informational purposes only, to help obtain funding and identify regions most in need.</i> ) County _____ Zip code/City _____ Is the cat being fed regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No Gender of person feeding cat: <input type="checkbox"/> Female <input type="checkbox"/> Male Age of person feeding cat: <input type="checkbox"/> 18-40 <input type="checkbox"/> 41-60 <input type="checkbox"/> 61-80 <input type="checkbox"/> 80+ Occupation _____ Is this person on financial assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Special instructions/comments:					

**CLINIC USE ONLY**

**ANESTHESIA**

Gender <input type="checkbox"/> F <input type="checkbox"/> M	Weight/lbs	Anesthesia cocktail cc.	Time	Add'l anesthesia cc.	Time	Iron cc.
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**PREP**

**CLINIC COMMENTS**

**SURGERY & POST-OP**

<p>(<i>ND=Not Done</i>)</p> <input type="checkbox"/> Chip Scan <input type="checkbox"/> Exam Lactating: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ear Tip <input type="checkbox"/> ND <input type="checkbox"/> Tattoo <input type="checkbox"/> ND <input type="checkbox"/> Rabies Vac. <input type="checkbox"/> ND <input type="checkbox"/> FVRCP Vac. <input type="checkbox"/> ND <input type="checkbox"/> Flea Control <input type="checkbox"/> ND <input type="checkbox"/> Blood Draw <input type="checkbox"/> ND  <input type="checkbox"/> Penicillin _____ cc. <input type="checkbox"/> ND <input type="checkbox"/> Fluids _____ cc. <input type="checkbox"/> ND		<input type="checkbox"/> Buprenex _____ cc. <input type="checkbox"/> ND <input type="checkbox"/> Isoflurane used <input type="checkbox"/> ND Cat was: <input type="checkbox"/> Normal <input type="checkbox"/> Prev. altered <input type="checkbox"/> Pyometra <input type="checkbox"/> In heat <input type="checkbox"/> Post partum <input type="checkbox"/> Pregnant: # Feti _____ <input type="checkbox"/> Early <input type="checkbox"/> Middle <input type="checkbox"/> Late <input type="checkbox"/> Crypt 1 <input type="checkbox"/> Crypt 2  Additional procedures  <input type="checkbox"/> Surgeon's Initials _____
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