

Canine Surgery Form

Client Name: _____

Account #: _____

Arrival Time: _____

Patient Name: _____

Age: _____

Today's Weight: _____

Surgical Procedure

- | | |
|---|---|
| <input type="checkbox"/> Ovariohysterectomy | <input type="checkbox"/> Declaw (Front Only) |
| <input type="checkbox"/> Castration | <input type="checkbox"/> Dewclaw removal (Specify Locations: _____) |
| <input type="checkbox"/> Tumor removal (QTY. _____) | <input type="checkbox"/> Umbilical Hernia |
| <input type="checkbox"/> Histopath | <input type="checkbox"/> Abdominocentesis |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Other (please specify) |

Routine Services *(Please circle 'Y' to accept or 'N' to decline the service)*

Vaccinations:

Y N Rabies

Y N DA2PP

Y N Lepto

Y N Bordetella

Y N Lyme

Additional Services:

Y N Microchip

Y N Nail trim

Y N Express Anal Glands

Y N Clean ears

Diagnostic Tests:

Yes Physical Exam *(Mandatory)*

Y N Fecal Floatation – to look for intestinal parasites

Y N Heartworm/Tick Borne Disease Combination Test

Y N Blood screening profile: _____

Y N Senior blood work (CBC/Chem/ T4)

Y N Thyroid Test

Y N Urinalysis

Y N Radiographs

Medical History Questions *(Please check all that apply)*

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> No Concerns at this time | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Coughing | <input type="checkbox"/> Scratching Ears Check |
| <input type="checkbox"/> Ate or Swallowed a Foreign Object | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Urinating Frequently | <input type="checkbox"/> Growth/tumor |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Straining to urinate | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Blood in Stool (Circle: Bright Red or Dark) | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Increased Drinking | <input type="checkbox"/> Abnormal Behavior |
| <input type="checkbox"/> Not Eating | <input type="checkbox"/> Shaking head | <input type="checkbox"/> Other (please specify) | <input type="checkbox"/> Bite Wound |
| <input type="checkbox"/> Losing Weight | | | <input type="checkbox"/> Lameness/limping |
| <input type="checkbox"/> Difficulty Breathing | | | |

Specify Complaint(s): (ex. Left leg pain; Growth on face; hiding; etc.)

Duration of Condition(s): (hours, days, weeks, etc.)

List any medications your pet has received in the last 24 hours:

Name of medication

Amount Given

Time Given

Consent for Treatment

As owner, or duly authorized agent of owner, I authorize CACC to proceed and accept full financial responsibility for all diagnostic tests and treatment included in the estimate for services and for any emergency services should they be necessary. I acknowledge that risks and the possibility of complications exist in any surgical or medical treatment and I am assuming all risk involved. If your pet is not current on tick/flea preventions and live parasites are found on or around them, we will administer a treatment. I agree that in the case of nonpayment, a fee of 1.5% per month will be charged. All collection and attorney fees necessary to collect this debt will be born to me.

Please Sign: _____

Date: _____

Canine Surgery Form