Feline Surgery Form

Client Name: _____ *Account #:* _____ *Arrival Time:* _____

Patient Name: _____ *Age:* _____ *Today's Weight:* _____

Surgical Procedure

- ☐ Ovariohysterectomy
- ☐ Castration
- ☐ Tumor removal (QTY. _____)
- ☐ Histopath
- ☐ Dental
- ☐ Declaw (Front Only)
- ☐ Dewclaw removal (Specify Locations:_____)
- ☐ Umbilical Hernia
- ☐ Abdominocentesis
- ☐ Other (please specify)

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

Vaccinations:

Y N Rabies
Y N FVRCP
Y N Leukemia

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 Feline Leukemia/Feline Immunodeficiency Virus
Y N Fecal Floatation – to look for intestinal parasites
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)*

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

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:*_____