



Prevent Homeless Pets
Phone: 509-497-1133

Canine Medical Record

Please fill out one form per dog.

Dog #

Clinic Date / /		Surgical Waiver Signed by: <input type="checkbox"/> Agent <input type="checkbox"/> Owner/caretaker		Please give this dog (check all that apply): <input type="checkbox"/> DA2Pv Vaccine (first Booster) <input type="checkbox"/> Rabies Vaccine (1 year) <input type="checkbox"/> Microchip Health Status Appetite last 72 hrs: <input type="checkbox"/> Normal <input type="checkbox"/> Little <input type="checkbox"/> None Fed Breakfast: <input type="checkbox"/> yes <input type="checkbox"/> no Health History: (check all seen within last week) <input type="checkbox"/> Coughing <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Low energy List any treatment in last mo. _____ Chronic health problems: (check all you suspect your pet has) <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart problem <input type="checkbox"/> Seizures Special Instructions/Comments/Health Concerns:
Today's contact (agent)		Phone		
Name of Owner/caretaker, if different		Phone		
Owner's Street Address				
City		State	Zip code	
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Age <input type="checkbox"/> Not sure <input type="checkbox"/> Mo. <input type="checkbox"/> Yr.	Dog's Name:		
Breed:		Dog is:		
Color		<input type="checkbox"/> Tame <input type="checkbox"/> Untouchable <input type="checkbox"/> Not sure		

Clinic Use Only

Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Weight:	<input type="checkbox"/> Females Performed OHE via midline incision, Pedicles- _____ PDS/ PGCL/Catgut Uterus- _____ PDS/ PGCL/Catgut Closure- _____ PDS/ PGCL simple interrupted/ continuous/ Cruciate linea and intradermal skin closure. <input type="checkbox"/> Males Performed closed neuter via pre-scrotal/scrotal midline incision Testicles- _____ PDS/Catgut PGCL /self Closure- _____ PDS/ PGCL/ Vetbond simple interrupted/continuous/Cruciate linea and intradermal skin closure.	Observed in clinic: Fleas Tapeworms Ear Discharge Diarrhea Eye discharge Nasal discharge Additional Notes:
Prep _____ ml M15 _____ ml Ace (10mg/ml) _____ ml K _____ ml Mz _____ ml TKX Isoflurane Mask Tube ND Bupivacaine (0.5%) ND <input type="checkbox"/> _____ ml IT <input type="checkbox"/> Splash block <input type="checkbox"/> Pen G _____ ml SQ <input type="checkbox"/> Meloxicam (5 mg/ml) _____ ml SQ			
Recovery (check when complete) <input type="checkbox"/> Time _____ <input type="checkbox"/> Temp: 1) _____ 2) _____ 3) _____ <input type="checkbox"/> Sugar Syrup PO <input type="checkbox"/> Fluids _____ ml LRS SQ <input type="checkbox"/> DA2Pv Vac. <input type="checkbox"/> NR <input type="checkbox"/> Rabies Vac. <input type="checkbox"/> NR		Dog was: <input type="checkbox"/> Normal <input type="checkbox"/> Previously altered <input type="checkbox"/> Crypt 1 <input type="checkbox"/> Crypt 2 <input type="checkbox"/> In heat <input type="checkbox"/> Post partum <input type="checkbox"/> Fatty <input type="checkbox"/> Friable <input type="checkbox"/> Pregnant: # Feti _____ <input type="checkbox"/> <input type="checkbox"/> Early <input type="checkbox"/> Middle <input type="checkbox"/> Late	Recovery: (1 st 12-18 hrs.) Keep warm (70 – 75 degrees) Light meal and water when alert Quiet activity. Females-check incision for 2 wks. Meds: None <input type="checkbox"/> Meloxicam 7.5mg tab _____ tablet(s) once daily for 3 days. <input type="checkbox"/> Meloxicam oral 1.5mg/ml _____ (1 syringe) once daily for 3 days
Surgeon's initials _____		Additional Procedures:	