



# Feline Surgical Record

Cat #

Prevent Homeless Pets  
Phone (509) 497-1133

Please fill out one form per cat.

Clinic Date / /		Surgical Waiver Signed by: <input type="checkbox"/> Agent <input type="checkbox"/> Owner/caretaker		<b>Please give this cat</b> (check all that apply): <input type="checkbox"/> <b>FVRCP Vaccine</b> (Distemper, first booster) <input type="checkbox"/> <b>Rabies Vaccine</b> (4 lbs. and over, 1 year) <input type="checkbox"/> <b>Flea Control</b> – as needed <input type="checkbox"/> <b>Felv/FIV test</b> <input type="checkbox"/> <b>Microchip</b>  <b>Health Status</b> 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"/> Snotty nose <input type="checkbox"/> Runny eyes <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Low energy List any shots 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		
Cat's Sex: <input type="checkbox"/> Not sure <input type="checkbox"/> Female <input type="checkbox"/> Male	Age <input type="checkbox"/> Not sure <input type="checkbox"/> Mo. _____ <input type="checkbox"/> Yr.	Cat's Name: <input type="checkbox"/> no name			
Coat Length: <input type="checkbox"/> SH <input type="checkbox"/> MH <input type="checkbox"/> LH	Cat is:				
Color:	<input type="checkbox"/> Tame <input type="checkbox"/> Untouchable <input type="checkbox"/> Not sure				
<input type="checkbox"/> <b>Ear Tip</b>		- or -		<input type="checkbox"/> <b>Tattoo/No Ear Tip</b>	

### Clinic Use Only

Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Weight:	<b>Females</b>		Observed in clinic: Fleas Tapeworms  Ear Discharge  Diarrhea  Eye discharge  Nasal discharge  Woods Lamp  Additional Notes:
<b>Prep</b>		Performed OHE via midline incision, Pedicles-_____PDS/PGCL/Catgut/ Self Uterus-_____PDS/PGCL/Catgut Closure-_____PDS/PGCL simple interrupted/ continuous/ Cruciate linea and intradermal skin closure.		
<input type="checkbox"/> _____ml TTDex IM  Isoflurane <input type="checkbox"/> Mask <input type="checkbox"/> Tube <input type="checkbox"/> ND  <input type="checkbox"/> _____ml Hm (2mg/ml) IM <input type="checkbox"/> Bupivacaine (0.5%) <input type="checkbox"/> Lidocaine 2% <input type="checkbox"/> _____ml IT <input type="checkbox"/> Splash block <input type="checkbox"/> Pen G _____ml SQ <input type="checkbox"/> Convenia _____ml SQ Microchip: <input type="checkbox"/> None found <input type="checkbox"/> #: _____		<b>Males</b>		
<b>Recovery</b> (check when complete)		CLOSED CASTRATION with scrotal incision, self-ligation  <input type="checkbox"/> Ear tip <input type="checkbox"/> Tattoo <input type="checkbox"/> ND  <b>Cat was:</b> <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"/> Obese <input type="checkbox"/> Friable <input type="checkbox"/> Pregnant: # Feti _____ <input type="checkbox"/> Early <input type="checkbox"/> Middle <input type="checkbox"/> Late <input type="checkbox"/> Lactating _____		
<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"/> _____ml Meloxicam (5 mg/ml) SQ <input type="checkbox"/> _____ml Meloxicam (1.5 mg/ml) PO <input type="checkbox"/> _____ml Robenacoxib (20 mg/ml) SQ <input type="checkbox"/> FVRCP Vac. <input type="checkbox"/> NR <input type="checkbox"/> Rabies Vac. <input type="checkbox"/> NR <input type="checkbox"/> Flea Control _____ml (selamectin) <input type="checkbox"/> Praziquantel _____ <input type="checkbox"/> Post-op weight _____		Additional Procedures: _____  Recovery: (1 <sup>st</sup> 12-18 hrs.) Keep warm (70 – 75 degrees) Light meal and water when alert. Quiet activity. Ferals confined. Females-check incision for 2 weeks.		
Surgeon's initials				