



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		Please give this cat (check all that apply): <input type="checkbox"/> FVRCP Vaccine (Distemper, first booster) <input type="checkbox"/> Rabies Vaccine (4 lbs. and over, 1 year) <input type="checkbox"/> Flea Control – as needed <input type="checkbox"/> Felv/FIV test <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"/> 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	Age <input type="checkbox"/> Not sure	Cat's Name: <input type="checkbox"/> no name			
<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Mo. <input type="checkbox"/> Yr.				
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"/> Ear Tip		- or -		<input type="checkbox"/> Tattoo/No Ear Tip	

Clinic Use Only

Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Weight:	Females 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. Males CLOSED CASTRATION with scrotal incision, self-ligation <input type="checkbox"/> Ear tip <input type="checkbox"/> Tattoo <input type="checkbox"/> ND	Observed in clinic: Fleas Tapeworms Ear Discharge Diarrhea Eye discharge Nasal discharge Woods Lamp Additional Notes:
Prep <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 Microchip: <input type="checkbox"/> None found <input type="checkbox"/> #: _____			
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"/> _____ml Meloxicam (5 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 _____ Surgeon's initials _____		Additional Procedures: _____	