RASCAL UNIT
Roaming Animal Sterilization Clinic at Low cost

Surgery Date ___/___/___

FELINE TREATMENT AUTHORIZATION and MEDICAL RECORD

Owner name: _____Date: ____/____/____

Address: _____

City: _____ State: ____ Zip: _____ County: _____

Phone #: (____) _____ E-mail:_____

Cat's name: _____ Color: _____ Age/DOB: _____ Breed: _____ M/F: ____

Exam: $10

Parasite Control:

___ Flea topical treatment*
___ Dewormer*
___ Ear clean / Ear mite treatment $5-10.00

* Please ask for price and product available at time of clinic

Clinic Admin fee if applicable $_____

Vaccination and Identification:

___ Rabies $7.00
___ FVRCP $10.00
___ Leukemia $13.00

___ Microchip $25.00

Labwork:

___ Felv/FIV/Heartworm $25.00
___ Fecal Examination*
___ Junior Wellness Pofile*
___ Senior Wellness Profile*

Additional Services requested or recommended: _____

I, the undersigned, certify that I am the owner, or authorized agent, of the animal described above. I authorize the doctor on duty and assistants to perform the procedures listed above, including the administration of pain relief medications, sedatives and anesthetics. I have been advised as to the nature of the procedure, the potential risks, and at-home care. I also understand that no guarantee of successful treatment can be made. If my pet is in need of post surgical care, I may contact RASCAL Unit for a no-charge recheck at their location (fees for medications or procedures may apply) or seek another veterinary hospital at my own expense.

Signature of owner/agent: _____

_____

For Clinic Use Only

Wt(lbs): _____ T: _____ P: _____ R: ____ BCS: ____/ 9 Dental Score: ____/ 4

Examination Findings:_____

Diagnostics:_____

Prescriptions:_____

Recommendations:_____

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PATIENT CHECK-IN INFORMATION

Please fill in all information as completely as possible to ensure optimal care for your pet.
This for must be filled on the day of surgery, not before.

Owners Name: _____Patient's Name: _____

Telephone number where we can reach you today: (____) _____

How long have you owned this cat? _____

Where did you obtain this cat? _____

Is the cat (circle one): Indoor Only Outdoor Only Indoor/Outdoor Stray/Feral

Has your pet displayed any of the following in the last 2 weeks: (check if yes)
Sneezing ____ Coughing ____ Vomiting ___ Diarrhea ___

Has your cat ever had a seizure? Yes No
If yes, explain: _____

Has your cat had any previous… (circle yes or no):
…Illness? Yes No If yes, please explain: _____
…Injuries? Yes No If yes, please explain: _____
…Surgery? Yes No If yes, please explain: _____
…Drug or vaccine reaction? Yes No If yes, please explain: _____

Is your cat on any long-term medications? If so, list all _____

Has your cat been given any medications in the last month? If so, list type and why it was given
_____

IF your cat is an intact (unsprayed) female:
When was her last heat cycle? _____ Unsure
Has she had any litters? If so, when was the last time? Yes _____ No
Is your cat pregnant? (circle one) Yes No Could be

Has your cat been treated or dipped for fleas/ticks in the last month? Yes No
If yes, what product was used? _____

When was the last time your cat was Leukemia/FIV tested? _____ Not tested

Is your cat on monthly flea and/or heartworm prevention? Yes No
If yes, what type? Frontline Revolution Advantage Multi Other: _____

How did you hear about RASCAL? _____

Do you have a regular veterinarian? Yes No