



Clinic 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

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 Profile*
- ___ 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: _____



Clinic Date ___/___/___

PATIENT CHECK-IN INFORMATION

**Please fill in all information as completely as possible to ensure optimal care for your pet.
This form 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 (unspayed) 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