

*****CHECKS PAYABLE TO HSMC AND MAILED TO*****

*****HSMC PO BOX 298 MT GILEAD, OH 43338*****

CLINIC USE ONLY:

CAT ____ OF ____



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PAID C/CK# ____ \$ ____

Surgery Date 4 / 30 / 2023

FELINE SURGERY AUTHORIZATION and MEDICAL RECORD

Owner name: _____ Date: ____ / ____ / ____

Address: _____

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

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

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

Surgery:

- Spay / Neuter
- Ear Tip (TNR/feral) no additional charge
- Dental (Average range \$100 - \$150)
- Other: _____ \$ _____
- Additional oral pain meds \$10 (3 days)*

Parasite Control:

- Broad spectrum Dewormer*
- Heartworm Prevention*
- Flea/Tick Control*
- Ear Clean / Mite Treatment \$15

Organization Admin fee: \$ _____

Vaccination and Identification:

- Rabies \$10.00 **INCLUDED IN PRICE**
- FVRCP \$14.00
- Leukemia \$20.00
- Microchip \$30.00

Labwork:

- Pre-Anesthesia Bloodwork \$60
- Junior Wellness Profile \$65 (Outside Lab)
- Senior Wellness Profile \$125 (Outside Lab)
- FeLV/FIV Test \$35.00
- Fecal Examination \$35.00-40.00

Buster Collar (E-Collar) \$15

By initialing I am confirming I was offered an e collar and declined _____

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 veterinary staff to perform the services listed above, including the administration of pain relief medications, sedatives, and anesthetics. I understand that, although rare, there are risks with any medical treatment, sedation and anesthetic procedure including drug/vaccine reactions, infection and death. I also understand that no guarantee of successful treatment can be made.

Signature of owner/agent: _____

For Clinic Use Only (do not write in fields below)

Wt. (lbs.): _____ Notes: _____

Pre Med: _____

Induction: _____

Procedure Description: _____

Add'l Notes: _____
