Original Medical Record

Today's date:

Pet:		**Client ID:**	**(Office Use)**
Species:	**FELINE**	Owner:	
Breed:		Address:	
Color:		City/State:	
Age:		Zip:	
Sex:		Phone 1:	
Weight:		Phone 2:	
Allergies:		Email:	

Has this animal ever had any reaction to vaccinations, drugs, or medications? Yes ____ No ____
If yes, please explain _____
Has this animal bitten or scratched anyone in the past 10 days? Yes ____ No ____

___I, being of legal age and responsible for the animal described above, have the authority to grant the Chesapeake Humane Society C.A.R.E. Clinic and its staff members, volunteers, or agents my consent to vaccinate the animal named above.

___I understand that modern techniques and trained staff will be used to care for all animals and that reasonable precautions will be used against injury, escape, or destruction of the animal. It is thoroughly understood that the Chesapeake Humane Society C.A.R.E. Clinic, its staff, volunteers, and agents will not be held liable or responsible in any manner and that I assume all risks.

_____

Signature Date

Available services for your CAT

☐ Vaccine Clinic Exam, $10

☐ Surcharge -Unaltered Pet x ____ ☐ Scheduling Deposit

☐ Aggressive Fee, $20

☐ Rabies, $15 - __1yr __3yr (requires previous certificate)

☐ FVRCP, $20 __1st __2nd __ 3rd __1y __ 3y

☐ FeLV/FIV/HW Combo Test $30 (Results:____/___/____ Call ☐

☐ De-worming: Strongid _____cc Profender (S__ M__ L__)

☐ Microchip $30: _____

☐Flea preventative:
Revolution/Bravecto x ____
Other _____ x ____

☐ I decline flea preventative for my pet

☐ City License: __Altered pet, $4 __Unaltered pet, $10

Additional Services:
☐Ear Cytology, $15:_____
☐Ear Cleaning, $15: ____
☐Claro medication, $20 per ear: ___Left ___Right

☐Diphenhydramine 50mg/ml, $15 _____cc _____ time

Weight: _____ # / Kg
BCS: __/9 _____
CRT/MM: _____
Coat/Skin: _____
Eyes: _____
Ears: _____
N/T: _____
Dental Calc: __/5 _____
H/L: _____
GI/UG: _____
M/S: _____
Neuro: _____
LN: _____

Assessment:_____

Plan: _____

Dental Consult:
Periodontal Disease: ____/___
Dental Slots ___ Extractions _____

Vaccine Labels

Completed
Initials ___
Date____

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