



**For Office Use ONLY:**

Intake Date: \_\_\_/\_\_\_/\_\_\_  
 Program:  AWASA  TALGV  S/N Sol.  PFA  PACC  SELF-PAY  
 Certificate #: \_\_\_\_\_ COPAY: \$ \_\_\_\_\_ Check in by \_\_\_\_\_

**SURGICAL CONSENT FORM: Type of Surgery \_\_\_\_\_**

**THE PAYMENT OF YOUR BILL IS DUE IN FULL AT THE TIME THIS ANIMAL IS RELEASED**

<b>Client Name:</b> _____ <b>Address:</b> _____ <small>Street Apt/Unit#</small> <small>City State Zip</small> <b>Phone #:</b> Primary _____ Other _____	<b>Patient Name:</b> _____ Species: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Age: _____ wks/mo/ys Breed: _____ Color: _____
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**Patient History**

1. Where did you get your pet? \_\_\_\_\_
2. How long have you owned your pet? \_\_\_\_\_
3. Does your pet have any current or recent illness or injuries?  No  Cough  Sneeze  Vomiting  Diarrhea  Other: \_\_\_\_\_
4. Has your pet ever had ANY surgery in the past? .....  Yes  No
5. Has your pet ever had an allergic reaction to a vaccination or medication? .....  Yes  No
6. Is your pet currently taking any medication? .....  Yes  No
7. When (date & time) did your pet last have food to eat? \_\_\_\_\_
8. FEMALES ONLY: Number of litters \_\_\_\_\_ Date of last litter \_\_\_\_\_ Date of last heat \_\_\_\_\_
9. Has your pet been vaccinated?  No If Yes: **Dogs:** Parvo \_\_\_/\_\_\_/\_\_\_ INAPB \_\_\_/\_\_\_/\_\_\_ Rabies \_\_\_/\_\_\_/\_\_\_  
 No Proof of Vaccines but current per owner **Cats:** PRC \_\_\_/\_\_\_/\_\_\_ FeLV \_\_\_/\_\_\_/\_\_\_ Rabies \_\_\_/\_\_\_/\_\_\_

ALL PATIENTS DIAGNOSED WITH FLEAS AND/OR TICKS ARE REQUIRED TO BE TREATED BY SANTA CRUZ VETERINARY CLINIC AT A FEE OF \$15.

This is for the safety of your pet and other patients in this hospital.

I am the owner and/or designated person to authorize for medical care for the above described pet. I hereby allow Santa Cruz Veterinary Clinic to examine, prescribe for, and/or treat the above described pet. I assume all responsibility for charges acquired in the care of this animal. I also understand that these charges will be paid at time of release and deposit may be required for inpatient care. If inpatient care is required I understand that personnel is not present on premises 24hrs a day. I understand that the doctors and staff will use all reasonable precautions against injury, escape, or death of my pet. I understand that all anesthesia involve some risks to my pet and I will not hold the doctor and staff responsible under any circumstances. I understand I am responsible for following post anesthetic/surgical recovery instructions to avoid serious injury or even death to my pet. All animals spayed/neutered may be tattooed for identification. I understand that I assume all risks.

**Quote:\$      Signature:      Print Name:      Date:**

**ADDITIONAL SERVICES**

1. Would you like to vaccinate you pet today? **Please Initial**  
**Cats:** PRC (\$35) \_\_\_ FELV (\$35) \_\_\_ RV (\$15) \_\_\_ **Dogs:** DAPP (\$35) \_\_\_ INAPB (\$35) \_\_\_ RV (\$15) \_\_\_
2. Do you wish to have your **CAT** tested for Feline Leukemia and F.I.V? ..... \$35.00 (Initial) Yes \_\_\_ No \_\_\_
3. Do you wish to have your **DOG** tested for tick fever, heartworm, and lyme disease?..... \$35.00 (Initial) Yes \_\_\_ No \_\_\_
4. Do you wish to have your pet's nails trimmed? ..... \$15.00 (Initial) Yes \_\_\_ No \_\_\_
5. Do you wish to have your pet microchipped? ..... \$25.00 (Initial) Yes \_\_\_ No \_\_\_
6. Do you wish to go home with post op pain relief for your 4 month or older pet? \$15-20 (Initial) Yes \_\_\_ No \_\_\_
7. Do you want to deworm your dog for intestinal parasites?..... \$10.00 (Initial) Yes \_\_\_ No \_\_\_
8. Do you want topical feline deworming for your cat? (in house application) ..... \$15.00 (Initial) Yes \_\_\_ No \_\_\_
9. Do you wish to go home with an E-Collar on your pet? ..... \$10.00 (Initial) Yes \_\_\_ No \_\_\_
10. Do you wish to do pre-op blood work prior to anesthesia today?..... \$95.00 (Initial) Yes \_\_\_ No \_\_\_
11. Do you wish to License your DOG with Pima County?....(Fee Varies) Lic \$ \_\_\_ Late \$ \_\_\_ (Initial) Yes \_\_\_ No \_\_\_
12. Additional recommendation (per DVM) \_\_\_\_\_ \$ \_\_\_ (Initial) Yes \_\_\_ No \_\_\_

**PRE-OP EXAM:** Weight (lbs) \_\_\_\_\_ Temp ( E R ) \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_ M/C Scan: Neg / Pos \_\_\_\_\_

<b>Physical Exam:</b> Cardio/Pulmonary <input type="checkbox"/> N <input type="checkbox"/> Ab. Integumentary <input type="checkbox"/> N <input type="checkbox"/> Ab. Musculo-Skeletal <input type="checkbox"/> N <input type="checkbox"/> Ab. Digestive <input type="checkbox"/> N <input type="checkbox"/> Ab. Genito-Urinary <input type="checkbox"/> N <input type="checkbox"/> Ab. EENT <input type="checkbox"/> N <input type="checkbox"/> Ab. Mucous Membranes <input type="checkbox"/> N <input type="checkbox"/> Ab.	<b>BCS=</b> _____ / 9 <input type="checkbox"/> Remote Visual or Brief Exam – Caution or Feral	<b>Veterinarian Signature</b> _____
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