

Feral Cat Form

ROCKY SHORES



VETERINARY HOSPITAL

341 Route 25A Rocky Point, NY 11778  
631-209-2035

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rockyshoresvets@hotmail.com

S	N	Crypt	Preg/Pyo/Hydr	Obese	Hernia
			AdvM	Felv/FIV/HW	

Surgical Procedure:

Ligatures (3-0 abs. mono.)  Pedicle tie

Closure(3-0 abs. mono.):

2-lay  3-lay  S.C.  Ct

Surgical Adhesive

**YOUR INFORMATION** (please print)

Last name \_\_\_\_\_

First name \_\_\_\_\_

Private rescuer  Non-Profit  Municipal/gov't

Name of Rescue/Shelter Organization \_\_\_\_\_

\_\_\_\_\_

Mailing Address \_\_\_\_\_

City/Zip Code \_\_\_\_\_

**Contact Information:**

Phone numbers:

Primary \_\_\_\_\_

Secondary \_\_\_\_\_

Ace/Bup(mg) \_\_\_\_\_ / \_\_\_\_\_ IM Metacam(mg) \_\_\_\_\_ SC  
 Ketamine(mg) \_\_\_\_\_ IM Diazepam(mg) \_\_\_\_\_ IV  
 Telazol(ml) \_\_\_\_\_ IM

**ANIMAL INFORMATION:**

Sex M F Approx. Age \_\_\_\_\_

Color \_\_\_\_\_ Markings \_\_\_\_\_

Weight (lbs) \_\_\_\_\_

BCS	1	2	3	4	5
CV	N	A			
Resp	N	A			
EENT	N	A			
Repro	N	A			
Int	N	A			
Neuro	N	A			

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I have examined this animal prior to performing surgery. This exam may have been done under sedation/anesthesia if the animal was not able to be handled without prior sedation.

\_\_\_\_\_  
Veterinarian's Signature

I certify that I am 18 years of age or older and that the above information is true to the best of my knowledge. I, being the "client" or authorized agent for the client, have the authority to grant Rocky Shores Veterinary Hospital my consent to examine, perform surgery on, prescribe for, and /or treat the animal(s) for which I enter into this veterinarian-client-patient relationship. I fully understand the risks associated with anesthesia and surgery, and that without pre-surgical bloodwork the risks of complications including death are increased. \_\_\_\_\_ (client initials)

I have been informed that this animal may present in poor health, thereby increasing the risk of poor recovery, healing, and/or death, but still wish to proceed with surgery. \_\_\_\_\_ (client initials)

I understand that charges incurred at the time of surgery shall be paid for in full upon release of the animal(s) and that a deposit of at least 50% of the estimate of charges is required for groups of 15 or more cats, unless previous financial arrangements have been made with the owners of Rocky Shores Veterinary Hospital.

SIGNATURE OF CLIENT OR AUTHORIZED AGENT \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_