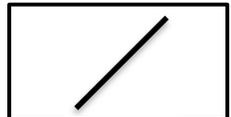


NWA COMMUNITY CAT PROJECT



Last Name/Rescue: _____ First Name _____ Date _____
 Phone: _____ Alternate Contact Info: _____
 Address: _____

Pet's Name: _____ Male Female
 Breed: _____ Color: _____ Age _____ months/years
 Rabies Immunization current? Y N Date: _____ Clinic: _____
 Is your cat allergic to medications or anesthesia? Y N If so, what kind? _____
 Past/Present Medical Problems: _____
 Cat is kept Indoors Outdoors Ever used a veterinarian before? Y N
 Has your cat had any litters of kittens? Y N How many litters? _____

DISCLAIMER

I understand that all surgery and anesthesia carries risks, and that unforeseen conditions may be present that cannot be detected without blood screening and which can increase the risks of abnormal bleeding or death. I understand that animals of advanced age, or that have never been vaccinated carry increased risk. I agree not to hold participating veterinarian(s) or their representative(s), other participating organizations and volunteer(s), or the facility liable for damages. This animal has had no food since midnight last night. I understand that if she is pregnant, the pregnancy may be terminated. All fees payable to the attending Veterinarian. **I agree to follow Post-Surgery Instructions.**

Owner Signature: _____ Date: _____

Requested Services:

NOTES

\$25 (Any Combo)

Spay (female)

Neuter (male)

Rabies

FVRCP

Microchip \$10

FIV/FeLV Test \$20

FIV/FeLV SNAP Test Result:

FIV: Positive Negative

FeLV: Positive Negative

Ear Tip FREE (for ferals)

Dewormer \$5

Nail Trim FREE

Flea Treatment \$5

Other: _____

Total Owed: \$ Total Paid: \$ Cash _____ Check _____ Donation _____ Comp _____

CERTIFICATE OF RABIES VACCINATION

The Village Low Cost Spay/ Neuter Clinic, 11114 Little Elm Road, Prairie Grove, AR 72753

Date of Rabies Vaccination: _____

RABIES
Label Here

FVRCP
Label Here

Next Vaccination Due: _____

Veterinarian _____

AR License Number _____

EXAM	DRUGS	SURGERY	TECHNIQUE	POST OP EXAM
Weight _____	<input type="checkbox"/> TKK	<input type="checkbox"/> Normal	<input type="checkbox"/> Scrotal	Temp _____
Temp N/A _____	<input type="checkbox"/> ISO	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Uterine Body Ligation	Fluids _____
	<input type="checkbox"/> Antisedan	<input type="checkbox"/> Cryptorchid	<input type="checkbox"/> Cruciate Body Wall	Rev. _____
	<input type="checkbox"/> Meloxicam	<input type="checkbox"/> Pyometra	<input type="checkbox"/> Continuous	
	<input type="checkbox"/> Telazol	<input type="checkbox"/> Already Altered		
	<input type="checkbox"/> Delorex			