



# CAT INTAKE FORM

## CONTACT INFORMATION

Owner/Trapper Name:	Phone (best # to reach you today) <input type="checkbox"/> Cel <input type="checkbox"/> Home <input type="checkbox"/> Work
Address:	City/State/Zip:
Driver License #:	Total # of Cats Today:

## CAT DESCRIPTION

Approximate Age: <input type="checkbox"/> Kitten (Under 5 Months) <input type="checkbox"/> Adult (6 Months and Older)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Sure
Color(s) / Pattern (Tabby, Calico, Tuxedo, Bi-color, etc):	This cat is a: <input type="checkbox"/> Pet <input type="checkbox"/> Stray/Feral <input type="checkbox"/> Foster in adoption program
Address (or nearest cross street) where cat was found:	Cat Name (If Applicable):

## SERVICES (payment due at check-in)

<input type="checkbox"/> Spay or Neuter (\$20.00 more for complications) \$ _____	<input type="checkbox"/> Feline Leukemia/FIV Heartworm Combo Testing .....\$25.00
<input type="checkbox"/> Rabies Vaccination ..... \$ _____	<input type="checkbox"/> Nail Trim ..... \$10.00
<input type="checkbox"/> FVRCP (Distemper) Vaccination..... \$15.00	<input type="checkbox"/> De-worming medicine to go home (pyrantel) .....\$15.00
<input type="checkbox"/> Feline Leukemia Vaccination.....\$25.00	<input type="checkbox"/> Other.....\$ _____
<input type="checkbox"/> Revolution™ Flea / Parasite Control ..... \$20.00	<input type="checkbox"/> Donation (Optional) ..... \$ _____
<input type="checkbox"/> Microchip.....\$30.00	<b>Total Due at Check-In: Cash / Check    \$ _____</b>

## SURGICAL WAIVER

I, the undersigned hereby request surgical/neuter services at The Cat Network's Miami Meow Mobile Spay/Neuter Clinic

I am the guardian or agent of the above described animal(s) and have authority to execute this consent

I hereby consent and authorize the performance of the following procedure(s):

Surgical Sterilization with Sterilization Tattoo (**MANDATORY**)

Rabies Vaccination

Initial \_\_\_\_\_  Ear-tipping. Required for all strays & indoor/outdoor cats.

I recognize and understand the risks inherent to anesthesia and surgery. I understand that the cats do not undergo a pre-anesthetic evaluation and I accept the risks of any underlying health problem that would complicate survival/recovery from the anesthesia and surgery.

I have taken precautions not to present a previously sterilized cat. I understand that if it is determined that my cat has been previously sterilized, a refund will not be issued.

I agree to hold harmless and indemnify Miami Dade County, The Cat Network, Inc and the Miami Meow Mobile, their officers, their volunteers and their employees from any loss, injury or damages to myself or the cat(s) arising out of or in any way connected to the services requested herein.

I understand that all cats will be scanned for microchips, and that if a microchip is found we reserve the right to contact the microchipping company and registered owner/agent of the cat.

I will ensure this cat receives food, water and necessary care while it is recovering until it can be returned to the location from which it was collected.

**We are a mobile unit, we cannot leave until you pick up your cat. You are receiving a subsidized service - which means it cost us more to provide this service than we are charging you. Please be respectful of our efforts by picking up your cat on time. There is a fee for late pick up.**

**I agree to pick up the cat(s) following the surgery as directed. I understand that no animal can be kept overnight at this facility, and if I fail to pick up the cat(s) on time as directed, then a \$50-\$100 late fee will be charged and/or the cat(s) may be declared abandoned and handled as such. (Florida Statute 828.13)**

I completely understand and agree with the above: Signature: \_\_\_\_\_

Signature when animal is picked up: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date:	Owner/Agent #	Cat #
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(For Clinic Use Only)	<b>CLINIC RECORD</b>	(For Clinic Use Only)
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<b>SEDATION</b>
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Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Estimated Age: _____ Years _____ Months
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Body Weight _____ pounds	
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DKT: _____ cc	Time: _____	Addt'l DKT: _____ cc	Time: _____	Addt'l DKT: _____ cc	Time: _____
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Microchip Scan <input type="checkbox"/> Chip <input type="checkbox"/> No Chip	Chip # if Found: _____
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<input type="checkbox"/> Rabies Vaccine <input type="checkbox"/> No Rabies Given - Reason: _____ <input type="checkbox"/> Dual Penicillin: _____ cc SQ <input type="checkbox"/> Midazolam: _____ cc IM / IV <input type="checkbox"/> Meloxicam: _____ cc SQ <input type="checkbox"/> Diazepam: _____ cc IM / IV	<u>Other Treatments:</u> <input type="checkbox"/> FVRCP Vaccine <input type="checkbox"/> FeLV Vaccine <input type="checkbox"/> Flea Med: Revolution (120mg/ml) _____ cc <input type="checkbox"/> Ivermectin _____ cc SQ <input type="checkbox"/> Combo Test (FeLV / FIV) <input type="checkbox"/> Positive: FeLV / FIV (circle one) <input type="checkbox"/> Negative <input type="checkbox"/> Nail Trim <input type="checkbox"/> Microchip  [ Attach Microchip # sticker here ]
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<u>Comments:</u>	
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<b>SURGERY</b>
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Surgeon: <input type="checkbox"/> Dr. Huntsman <input type="checkbox"/> Dr. _____	<input type="checkbox"/> Isoflurane <input type="checkbox"/> Oxygen <input type="checkbox"/> Mask <input type="checkbox"/> ET tube _____ mm
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<input type="checkbox"/> NEUTER → <input type="checkbox"/> Normal <input type="checkbox"/> Cryptorchid <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Inguinal <input type="checkbox"/> Abdominal Cord ligation: <input type="checkbox"/> Instrument Tie <input type="checkbox"/> Circumferential suture <input type="checkbox"/> Millers      Technique: <input type="checkbox"/> Open <input type="checkbox"/> Closed <input type="checkbox"/> SPAY → <input type="checkbox"/> Normal <input type="checkbox"/> Post-Partum <input type="checkbox"/> Lactating <i>Drying/Moderate/Engorged</i> <input type="checkbox"/> Pregnant - # of fetuses: _____ <input type="checkbox"/> In Heat <input type="checkbox"/> Pyometra	
Ventral midline incision; ovarian pedicles: <input type="checkbox"/> Instrument Tie <input type="checkbox"/> Circumferential suture <input type="checkbox"/> Millers Uterine Stump: <input type="checkbox"/> Circumferential <input type="checkbox"/> Millers Abdominal Closure: <input type="checkbox"/> Simple Interrupted <input type="checkbox"/> Simple Continuous <input type="checkbox"/> Cruciate Subcutaneous Closer: <input type="checkbox"/> Simple Interrupted <input type="checkbox"/> Simple Continuous <input type="checkbox"/> Cruciate Skin: <input type="checkbox"/> Intradermal Closure <input type="checkbox"/> Surgical Glue <input type="checkbox"/> <b>Previously Sterilized</b>	Suture: #3-0 MSA      #4-0 MSA Suture: #3-0 MSA      #4-0 MSA  Suture: #3-0 MSA      #4-0 MSA Suture: #3-0 MSA      #4-0 MSA Suture: #3-0 MSA      #4-0 MSA

<input type="checkbox"/> Tattoo (Ventral Midline)	<input type="checkbox"/> Ear Tip (left ear)	<input type="checkbox"/> NO Ear Tip
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<u>Comments:</u>	Medication Rx'd
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Euthanasia/Reason:	
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<b>RECOVERY</b>
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Reversal (if given): _____ cc IM      Time: _____	<input type="checkbox"/> SQ Fluids: _____ ml. (Type: _____)
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