SANTA CRUZ VETERINARY CLINIC
5408 S. 12th Ave. Tucson, AZ 85706
Phone #: (520) 889-9643
Fax #: (520) 889-9023
www.santacruzpet.com

For Office Use ONLY: Intake Date: ____/____/____
❑AWASA ☐TALGV ❑SNS ❑PACC ❑KFT ❑NKPC ❑ASAVET ❑SELF-PAY
COPAY: $_____ Check in by_____ PAGER # _____

Client Name: _____
Address: _____
Street Apt/Unit#
_____
City State Zip
Phone #: Primary_____
Other phone #: _____
Email:_____

Patient Name: _____
Species: ❑ **Dog** ❑ **Cat** ☐ _____
Sex: ❑ **Male** ❑ **Female** **# of pets today** _____
Age: _____ **wks/mo/yrs**
Breed: _____
Color: _____

WHAT SURGERY IS YOUR PET HERE FOR TODAY? ❑ Spay ❑ Neuter ❑Dental ❑Other: _____

1. Is your animal spayed or neutered? ☐Yes ☐No ☐ I don't know
2. Where did you get your pet? _____
3.. How long have you owned your pet? _____
4. Does your pet have any current/recent illness or injuries? ❑Yes ❑No ***list if yes***_____ ____
5. Has your pet ever had ANY surgery in the past? ***list if yes***……..……❑Yes ❑No
6. Has your pet ever had an allergic reaction to a vaccination or medication? ……...…….....❑Yes ❑No
7. Is your pet currently taking any medication? ***list if yes***…….……....❑Yes ❑No
8.When (date & time) did your pet last have food to eat? _____
9. FEMALES ONLY: Number of litters _____ Date of last litter _____ Date of last heat _____
10.Has your pet ever been vaccinated? ☐No If Yes, when? _____
❑No Proof of Vaccines but current per owner

ALL PATIENTS BROUGHT TO SANTA CRUZ WITH FLEAS OR TICKS ARE REQUIRED TO BE TREATED FOR A FEE OF $20

I am the owner and/or designated person to authorize medical care for the above pet. I hereby allow Santa Cruz Veterinary Clinic to examine, prescribe for, and/or treat the above pet. I assume all responsibility for charges acquired in the care of this animal. I also understand that charges must be paid at time of release and deposit may be required. If the above pet is receiving services that are paid for by an organization, I understand that my pet must be surgically sterilized (spay/neuter) at this time. If inpatient care is required, I understand that personnel are 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 and surgery involve risk of injury or death to my pet and I will not hold the doctor and/or staff responsible for unforeseen complications. I understand I am responsible for following post anesthetic/surgical recovery instructions to avoid serious injury or death to my pet. All animals spayed/neutered may be tattooed for identification. I understand that I assume all risks. Santa Cruz Veterinary Clinic is a clinical preceptor for the University of Arizona's College of Veterinary Medicine. I understand that my animal may have surgery performed or assisted by a veterinary student under direct supervision by the attending licensed veterinarian.

Signature: **Print Name:** **Date:**

ADDITIONAL SERVICES - *By selecting "yes," my signature above authorizes consent for the services to be performed.*

1.Vaccines: Dog: Rabies $18 _____DAPP $25_____ Bordatella $40_____Lepto $40_____
Cat: Rabies $18 _____ PRC $25 ____ FELV $40_____

2. $15.00 ☐Yes ☐No -E-Collar (dogs >6mo having surgery are required, or at Doctor's discretion)
3. $20-30 ☐Yes ☐No -Deworming for intestinal parasites dogs and cats.
4. $20.00 ☐Yes ☐No -Toe Nail Trim
5. $25.00 ☐Yes ☐No - Anal Glands
6. $25.00 ☐Yes ☐No - Microchip w/ Registration
7. $20.00 ☐Yes ☐No - Post op pain relief for your 4 month or older pet
8. $40.00 ☐Yes ☐No - Dog: Heartworm, Tick fever, and Lyme disease Test
9. $40.00 ☐Yes ☐No - Cat: FeLV/FIV Test
10. $100.00 ☐Yes ☐No - Pre-op blood work (CBC/Chem)
11. $_____ ☐Yes ☐No – Doctor recommendations:_____

QR code for post-op instructions video

Watch video before picking up your pet.

Weight(lbs):_____Temp (E R): _____Pulse:_____Resp:_____ M/C scan:Neg/Pos_____

PRE-OP EXAM:

MM/CRT:	___N	___AB	___NE
Gen. Apperance:	___N	___AB	___NE
Cardio/Pulmonary:	___N	___AB	___NE
Integumentary:	___N	___AB	___NE
Musculo-Skeletal:	___N	___AB	___NE
Digestive:	___N	___AB	___NE
Genito-Urinary:	___N	___AB	___NE
EENT:	___N	___AB	___NE
Dental:	N	AB	NE

BCS=_____/ 9 Room Tech_____ ❑Visual or Brief Exam – Caution or Feral

Vet Signature_____