



# 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

- ☐ Spay (female) \$15
- ☐ Microchip \$20
- ☐ Ear Tip FREE  
(Strongly recommended for ferals)
- ☐ Neuter (male) \$15
- ☐ FIV/FelV Test \$20
- ☐ Dewormer \$5 (Drontal)
- ☐ Rabies \$10
- FIV/FelV SNAP Test Result:**  
FIV: Positive Negative  
FelV: Positive Negative
- ☐ Nail Trim FREE
- ☐ FVRCP \$10
- ☐ Other: \_\_\_\_\_

Total Owed: \$ Total Paid: \$ Cash \_\_\_\_\_/Check# \_\_\_\_\_ Comp: \$

### CERTIFICATE OF RABIES VACCINATION

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

Date of Rabies Vaccination: \_\_\_\_\_  
Next Vaccination Due: \_\_\_\_\_

Rabies Label  
Here

FVRCP  
Label Here

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"/> Dolorex			