



MEDICAL RECORD

1-888-364-7729 ~ ssmobileclinic.org ~ clinic@samsimonfoundation.org ~ 10736 Jefferson Blvd #371, Culver City 90230

Client #: _____ Qual: _____

Microchip #: _____

Owner's Information:

Last Name: _____ First Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: () _____ Work Ph: () _____ Cell Ph: () _____

E-mail address: _____

If someone else is picking up your pet: Name: _____ Phone #: () _____

May we use: your pet's picture your picture both neither for education & outreach? This includes use in presentations, pamphlets and brochures, as well as on our clinic's social media accounts, such as Facebook. Your name will not be used without your express consent.

Pet's Information:

Pet's Name: _____ Species: Dog Cat Breed: _____

Age: _____ Weeks Months Years Sex: Male Female Color: _____

1. When did your pet last eat? _____

2. When were his/her last vaccinations? _____ What were they? _____

3. How long have you had this pet? _____ 3b. Is s/he: Indoors Outdoors Both

4. Medications your pet has taken for illness, fleas or ticks in the past month: _____ N/A

5. When was your pet's last veterinary exam? _____ Don't know N/A

6. Please list any prior illnesses or injuries: _____ Don't know N/A

7. If your pet is female, is she currently pregnant or in heat? Yes No Don't know N/A

8. If your pet is female, has she ever had puppies or kittens? Yes No Don't know N/A

8b. If so, when was the last time? _____

9. Has your pet ever had a bad reaction to vaccines, medication or anesthesia Yes No Don't know N/A

If yes, please explain: _____

10. Have there been any behavioral changes or signs of illness in the past 2 weeks? Yes No Don't know N/A

If yes, please describe: _____

Consent for Surgery:

As owner and authorized agent of the animal described above, I hereby grant The Sam Simon Charitable Foundation, as well as its employees, (hereinafter collectively referred to as "SSCF") my consent to perform surgery, administer anesthesia, and render any other treatment deemed necessary on said animal. I understand that if, during the course of treatment or surgery, the attending veterinarian deems it necessary to perform any additional procedure/s, this may be done at his/her absolute discretion.

I acknowledge that no assurance or guarantee has been made regarding the outcome of the surgery, and I understand that there are inherent risks of complications, up to and including death, from both the administration of anesthesia or medication, and from the surgery itself. I agree that I assume all risks, and will not hold SSCF liable in the event that an undesirable outcome, up to and including death, occurs during (or resulting from) treatment.

I understand that no overnight veterinary services are provided by SSCF, and that if I fail to retrieve my pet from the clinic on the day of surgery at the time designated to me by the clinic staff, my animal will be released to the appropriate local animal shelter in accordance with the policies established by SSCF. Should this happen, I understand that I will be responsible for all associated costs, and that SSCF is released from any and all further liability.

Client Signature: _____ Date _____

CLINIC STAFF ONLY:

1. General Appearance N A NE	2. Attitude N A NE	3. MM N A NE	4. C/V N A NE
5. Respiratory N A NE	6. Skin N A NE	7. PLNs N A NE	8. Abdomen N A NE
9. Neuro/Musculoskeletal N A NE	10. Ears N A NE	11. Eyes N A NE	12. Oral Cavity N A NE

Dr: _____