The Maryland SPCA Spay/Neuter Clinic is a high volume spay/neuter clinic. The procedures performed here are for the purposes of spaying/neutering cats and dogs; the Maryland SPCA Spay/Neuter Clinic is not a veterinary or emergency veterinary clinic. If issues arise that are directly related to the pet’s spay/neuter surgery, please contact the Maryland SPCA during our regular hours of operation weekdays from 7:30 am – 5:00 pm at 410-889-SPAY or fixem@mdspca.org. If you feel you need EMERGENCY help, please go to the nearest animal emergency center. If you seek medical care, please note that the Maryland SPCA is not financially responsible for your bills. The Maryland SPCA uses qualified staffing and approved materials and medications for all procedures performed. It is important that you understand that the risk of injury or death, although extremely low, is always present for surgery and anesthesia – just as it is for human beings.

I hereby release The Maryland SPCA, the veterinarians, assistants, and all of its employees and members from any and all claims arising out of or connected with the performance of this operation procedure. I agree that I have not claimed nor will I claim any right to compensation from any of the aforementioned parties, or file action by reason of such sterilization or attempted sterilization of such pet or any consequences related. The Maryland SPCA shall not be held responsible for any illness or defects which may have or may develop as a result of the procedure, nor shall The Maryland SPCA be liable for any damage or injury to person or property which may be caused by the pet.

I verify to the best of my knowledge that the pet named above is healthy and free of any pre-existing conditions that may further complicate the Spay/Neuter surgery and/or any treatments I have requested. _________ (initial)

To the best of my knowledge my pet is between 8 weeks to 7 years of age. _________ (Initial)

If my pet is cryptorchid (retained testicle/s) or has an observed reducible umbilical hernia, I consent to a $20 additional surgery fee. _________ (Initial)

Please initial if you would like these additional recommended services: Microchip ($25) _______ 4DX (Heartworm/Tick Screen) test ($25) _______

If my pet is found to have any of the following (fleas, intestinal parasites on visual inspection, skin infection):

I consent to any treatments necessary _________ (initial)

OR

Please call me before any treatments _________ (initial)

If the pet is not picked up at the agreed upon time of 4:00PM, the pet will be held at The Maryland SPCA and boarding fees will apply. If the pet is not picked up within 72 hours of the specified pick up time, the pet will be considered abandoned and I agree that The Maryland SPCA may make a final disposition of the pet in accordance with the rules of The Maryland SPCA. This may include, but is not limited to, placing the pet for adoption or humane euthanasia.

WE DO NOT PROVIDE 24-HR STAFF SUPERVISION

I understand that vaccinations and other veterinary treatments can cause adverse reactions in some pets. I hereby release The Maryland SPCA, the veterinarians, assistants and all other employees from any and all claims arising out of or connected with these vaccines and/or treatments.

By signing above I verify that I agree to all of the terms and conditions outlined within this disclaimer.

I would like to donate funds to The Maryland SPCA so they can help spay or neuter other pets in the community.

I am able to donate: ___$1 ___$5 ___$10 ___Other: $_________ Thank you for your donation!
Species: **DOG**  
Sex: M / F  
Pet Name: __________________  
Date: _____/_____/_____  
Pet ID: _____________

Rabies: □  
Da2PPV/L4: □  
Nail Trim: ________ ←INIT.  
TATTOO: □  
Revolution: □ (HW -)  
HW/4DX: + --

Microchip: □  
Client concerns/requests: _________________________

Examining Vet:  
□ Please check if exam was performed post-sedation. Reason: ______________________________

**S:** Admitted for elective spay/neuter surgery.  
Breed: _______________  
Color: _______________  
Approx. Age: _______

**O:**

<table>
<thead>
<tr>
<th>Ears/Eyes/Nose</th>
<th>N</th>
<th>ABN</th>
<th>Oral</th>
<th>N</th>
<th>ABN</th>
<th>Weight: ________</th>
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<tbody>
<tr>
<td>Lymph Nodes</td>
<td>N</td>
<td>ABN</td>
<td>Integument</td>
<td>N</td>
<td>ABN</td>
<td>TEMP #1: ________ Time: ________</td>
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<tr>
<td>Pulmonary</td>
<td>N</td>
<td>ABN</td>
<td>Cardiac</td>
<td>N</td>
<td>ABN</td>
<td>TEMP #2: ________ Time: ________</td>
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<tr>
<td>Upper Airways</td>
<td>N</td>
<td>ABN</td>
<td>Abdomen</td>
<td>N</td>
<td>ABN</td>
<td>TEMP #3: ________ Time: ________</td>
</tr>
<tr>
<td>Neurological</td>
<td>N</td>
<td>ABN</td>
<td>Musculoskeletal</td>
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<td>ABN</td>
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<tr>
<td>Uro-Genital</td>
<td>N</td>
<td>ABN</td>
<td>Hydration</td>
<td>N</td>
<td>ABN</td>
<td></td>
</tr>
<tr>
<td>Mucus Membranes</td>
<td>N</td>
<td>ABN</td>
<td>BCS (#/5):</td>
<td></td>
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</tbody>
</table>

**A:**  
Surgical anesthesia risk level (Please circle one):   1  2  3  4  5  
Notes: ________________________________________________

**P:**  
Approved for neuter/OHE?  
YES  NO : _________________________________________

Surgery Type: Performed by (if other than examining veterinarian): ________________________________ DVM

**Spay:**  
Neuter:  
Routine  
Normal Castration  
In Heat / Post Partum  
Cryptorchid  
Retained: L / R

**Incision:**  
Midline  
Other  
Scrotal  
Prescrotal  
Ligation:  
Autoligated  
or  ____________________________

**Suture:**  
Transfixed w/: ____________________________

<table>
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<tr>
<th>Abdomen:</th>
<th>Sub Q/Skin:</th>
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**Anesthesia/Analgesia Drugs**  
Tech Init  
Tech Init

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<tr>
<th>Telazol</th>
<th>IM</th>
<th>IV</th>
<th>Bupren. (0._mg)</th>
<th>IM</th>
<th>IV</th>
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<tbody>
<tr>
<td>Ketamine</td>
<td>IM</td>
<td>IV</td>
<td>Morphine:</td>
<td>IM</td>
<td>IV</td>
<td></td>
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<tr>
<td>Mid / ___</td>
<td>IM</td>
<td>IV</td>
<td>Ace:</td>
<td>IM</td>
<td>IV</td>
<td></td>
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<tr>
<td>Propofol</td>
<td>IM</td>
<td>IV</td>
<td>Butorphanol:</td>
<td>IM</td>
<td>IV</td>
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<tr>
<td>TTDex</td>
<td>IM</td>
<td></td>
<td>Antisedan:</td>
<td>IM</td>
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<tr>
<td>Carprofen, Inj</td>
<td>SQ</td>
<td></td>
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</tbody>
</table>

Maintained on Isoflurane  
Intubated: □  
ETT#: ____________

Surgery Notes: ________________________________________________

Prescribed:  
□ Capstar  
□ Revolution  
□ Convenia ________cc  
□ Other: ____________________________

□ Carprofen _____________ mg PO every 24 hours x ________ days. Next dose due ____________________