Client:	Patient:	Sex:
Date:	Patient Birthdate:	Species:
Phone:	Age:	Breed:

Anesthesia Assessment and Plan

Scheduled Procedure:_____ **Dr:** _____ **Date:** _____

(Owner to fill out highlighted areas) **Staff Initials**: _____

Patient History:	
Services Declined:	
Seizure History(note on chart if yes):	
Vaccine Reaction(note on chart if yes):	
Allergies:	
Last heat cycle:	
Previous Litters:	
Current Medications & Time Given:	
Time of Last Meal:	
Previous Anesthetic Procedures:	
Anesthetic Complications/Risk Factors:	
Orthopedic: Verify affected extremity	
Dental: Verify affected tooth/teeth	
Eye procedure: Verify affected eye(s)	
Mass Removal: Verify location(s)	

General Appearance	☒ Normal	☐ Abnormal	Remarks: __
Oral Cavity/Teeth	☒ Normal	☐ Abnormal	Remarks: __
Mucous Membranes	☒ Normal	☐ Abnormal	Remarks: __
Eyes	☒ Normal	☐ Abnormal	Remarks: __
Ears	☒ Normal	☐ Abnormal	Remarks: __
Cardiovascular	☒ Normal	☐ Abnormal	Remarks: __
Respiratory	☒ Normal	☐ Abnormal	Remarks: __
Gastrointestinal	☒ Normal	☐ Abnormal	Remarks: __
Musculoskeletal	☒ Normal	☐ Abnormal	Remarks: __
Lymph Nodes	☒ Normal	☐ Abnormal	Remarks: __
Urogenital	☒ Normal	☐ Abnormal	Remarks: __
Integumentary	☒ Normal	☐ Abnormal	Remarks: __
Nervous System	☒ Normal	☐ Abnormal	Remarks: __
Pain Present	☒ Normal	☐ Abnormal	Remarks: __

Emergency Plan

CPR Status: ☐ No CPR ☐ Basic CPR

Emergency Drug Doses for Patient:

Epinephrine	
Dopram	
Atropine	
Lidocaine	

Risk Assessment Number: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Examined By: __ Logged by: __