VMAT Mammal Patient Record				
Deployment/Event:			**Time:**	**Date:**
Clinician(s):			**Please Initial:**	
Procedure Location:				
Owner/Point of Origin:			**Holding Enclosure/Location #:**	
Contact Phone: ( )	**Address:**			
Service Animal Affiliation:				
Animal Name:	**Species:**	**Breed:**		**Color:**
VMAT ID #:	**Microchip #:**			**Photo #:**
Ear Tag #:	**Brand/Tattoo:**		**Other:**	
Gender: Male Female	**Neuter/ Spayed:** Yes ☐ No ☐	**Age/Birth:**		Estimate/Actual
Previous Weight: kg/gm/lb Estimate/Actual		**Current Weight:**	kg/gm/lb	Estimate/Actual
Sent To:				

Presenting Problem(s):					**Date:**
Previous Problem(s):					
Previous Treatments/Vaccines:					
Previous Diagnostics:					
Restraint Required: Yes ☐ No ☐		**Type:**			
Previous Anesthetic(s):	**Dosage**	**Total Dose:**	**Anesthetic Stage #:**	**Evaluation/Complications:** (excellent/good/fair/poor/unknown)	
	Per				
	Per				
Present	**Dosage**				
	Per				
	Per				
	Per				
Endotracheal Tube Size #:			**Procedure:**		

Physical Exam Checklist & Results			
Time:	**Body Temp:** *****C/F	**Pulse/Min:** /	**Respirations/Min:** /
MM Color:	**Capillary Refill Time (sec):**		**Subjective Hydration:**
General Body Condition: Obese/Good/Fair/Emaciated			
Appearance/Activity Level: Vigorous/Good/Weak/Unthrifty			
Visual Exam:			
Oral Exam:			
Ophthalmic:			
Otic:			
Palpation:			
Auscultation:			
Other Findings:			

VMAT Mammal Patient Record					
Diagnostic Procedures/Results					
On Site:	**PCV%:**	**TP:**	**BUN:**	**Glucose:**	**Other:**
Lab Name:					
Check All Sent: CBC: ☐ CHEM: ☐ Blood Smear: ☐ U/A: ☐ Other:					
Histopathology: ☐	**Source:**				
Feline Panel (FIP/FELV/FIV/TOXO): ☐ Coggins Test: ☐ Brucellosis: ☐					
Other Serology/Titers:					
Tuberculin Test MFG:		Exp. Date:		Isolate:	
Results:	24 hr:		48 hr:	72 hr:	
Other Results:					
Cultures/Cytology:					
Bacterial:		**Fungal:**		**Source:**	
Biopsy:		**Cytology:**		**Source:**	
Skin Scraping Site(s):					
Imaging:					
Radiographs:					
Ultrasound:					
Treatments;					
Antibiotics/dose:		**Anti-Parasites/dose:**			
Rabies Vaccine MFG:		**Serial #:**			
Other Vaccines:					
Vitamins/Minerals:					
Anti-inflammatory/Analgesics:					
Dental Procedures:					
Fluids: SQ:		**IV:**			
Assessment:					
Medical/Surgical Report/Other Procedures:					
Further Diagnostics:					
Long Range Plan/Rx:					
Housing/Diet:					