

NORTH COUNTRY WILD CARE PATIENT RECORD

Finder Information

Thank you for completing all information. This helps me keep my records and better help the animal.
 We pay for food and medicine for all animals that we accept. Donations are greatly appreciated. amount \$ _____

| | | | |
|--|---|-----|---|
| Today's date | Species | Sex | Rehabber |
| Finder | Phone | | E-Mail |
| Your Mailing Address Street _____ Town _____ Zip _____ | When Found? Date _____ Time _____ | | Where Found? <input type="checkbox"/> Same as mailing address Street _____ Town _____ |
| <input type="checkbox"/> injured <input type="checkbox"/> orphaned How? | Have you fed the animal? _____ If yes, what? | | Referred by? <input type="checkbox"/> Veterinarian <input type="checkbox"/> DEC <input type="checkbox"/> Sheriff <input type="checkbox"/> Other _____ |

Rehab Record

Initial Exam

| | | | |
|---|---|-------------------------|---|
| Performed by: | | Date: | Time: |
| Injuries? | | Cause of Distress code: | |
| Age: <input type="checkbox"/> juvenile <input type="checkbox"/> adult | Eyes open? <input type="checkbox"/> yes <input type="checkbox"/> no (if juvenile) | | Vet Consulted? <input type="checkbox"/> yes <input type="checkbox"/> no |
| Cold? <input type="checkbox"/> yes <input type="checkbox"/> no | Head: | Neck: | Abdomen: |
| Stressed? <input type="checkbox"/> yes <input type="checkbox"/> no | Teeth: | Mouth: | Throat: |
| Depressed? <input type="checkbox"/> yes <input type="checkbox"/> no | Eyes: L | R | Back: |
| Gasping? <input type="checkbox"/> yes <input type="checkbox"/> no | Ears: L | R | Tail: |
| Wheezing? <input type="checkbox"/> yes <input type="checkbox"/> no | Arms: L | R | Droppings: |
| Dehydrated? <input type="checkbox"/> yes <input type="checkbox"/> no | Legs: L | R | Fur: |
| Alert? <input type="checkbox"/> yes <input type="checkbox"/> no | Feet: LF | RF | LR |
| | | | RR |
| | | | Ectoparasites: |

Initial treatment

| Wound Treatment? | | | | |
|---|------|-----|--------|--------------------------|
| Fluids? <input type="checkbox"/> oral <input type="checkbox"/> tubed <input type="checkbox"/> subQ <input type="checkbox"/> IV <input type="checkbox"/> IO Medications? | | | | |
| Offered Food? Eaten? <input type="checkbox"/> yes <input type="checkbox"/> no | | | | |
| Date | Time | Age | Weight | Food, Meds, Observations |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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Disposition A B C1 C2 D1 D2 D3 Date _____ Transferred to _____