

Shelter Intake Exam Form

CART Name _____

Date & Time of Exam		Animal's ID #			Animal's Name		SPP (species)	
Age	Sex	F	FS	M	MC	Temp	Recheck Temp	
Examined By:	Name					<input type="checkbox"/> Veterinarian	<input type="checkbox"/> RVT	<input type="checkbox"/> Other _____
<input type="checkbox"/> Microchip Scan		Ears		Coat and Skin				
Implant: _____		<input type="checkbox"/> Normal <input type="checkbox"/> Other _____		<input type="checkbox"/> Normal <input type="checkbox"/> Other _____				
Attitude		Heart Rate _____ bpm		Nervous System				
<input type="checkbox"/> Normal/Alert <input type="checkbox"/> Other _____		<input type="checkbox"/> Slow <input type="checkbox"/> Fast <input type="checkbox"/> Other _____		<input type="checkbox"/> Normal <input type="checkbox"/> Other _____				
		<input type="checkbox"/> Murmur Grade (_____ /VI)						
		<input type="checkbox"/> Other _____						
Weight BCS _____ /9 _____ lbs		Lungs		Respiration Rate _____		Legs and Paws		
<input type="checkbox"/> Normal <input type="checkbox"/> Other _____		<input type="checkbox"/> Normal <input type="checkbox"/> Other _____		_____		<input type="checkbox"/> Normal <input type="checkbox"/> Other _____		
						Gait _____		
Eyes		Abdomen		De-Wormed: (product, dose, date)				
<input type="checkbox"/> Normal <input type="checkbox"/> Other _____		<input type="checkbox"/> Normal <input type="checkbox"/> Other _____		_____				
Mouth, Teeth, and Gums		Gastrointestinal System		Vaccinations Given				
<input type="checkbox"/> Normal <input type="checkbox"/> Other _____		<input type="checkbox"/> Normal <input type="checkbox"/> Other _____		Date: _____				
<input type="checkbox"/> Tarter <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Severe				Product(s): _____				
<input type="checkbox"/> Gingivitis <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Severe				Booster Date(s): _____				
Mucus Membrane Color								
<input type="checkbox"/> Pink <input type="checkbox"/> Pigmented <input type="checkbox"/> Other _____								
Nose and Throat		Urogenital System						
<input type="checkbox"/> Normal <input type="checkbox"/> Other _____		<input type="checkbox"/> Normal <input type="checkbox"/> Other _____						
Hydration		Lymph Nodes						
<input type="checkbox"/> Normal <input type="checkbox"/> Other _____		<input type="checkbox"/> Normal <input type="checkbox"/> Other _____						
Assessment: <input type="checkbox"/> Green <input type="checkbox"/> Yellow <input type="checkbox"/> Red <input type="checkbox"/> Black		Treatment and Recommendations:						

Local Jurisdiction _____

Shelter Location _____