

Date _____ Protocol # _____ Arrival Date: _____ Facility/Room # _____

Investigator _____ Species _____ Procedure: _____

Surgeon(s): _____ Anesthetist(s) _____ Survival or Non-survival (circle one)

Anesthetic Plan: (agent(s), concentration, dose, route): _____

Analgesic Plan: (agent(s), dose, route): _____

Pre-operative assessment: (date, condition): _____ Emergency Contact Phone # _____

USF ID	Group/ID	Weight (g)	Surgeon	Analgesic (time/amount)	Induction/Recovery (time)	Comments: (intra & immediate post-procedural assessments, complications, supplemental anesthesia, time of euthanasia, etc.)
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				/	/	

Post Operative Plan & Care
Observation / Treatment Dates : ___ / ___ / ___ - ___ / ___ / ___

Date & Time	*Analgesic Administered	Initials	Post-operative Observations: (e.g., Appearance/condition, abnormalities, incision site, appetite, voiding, suture removal)
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*Check box only when analgesics are administered