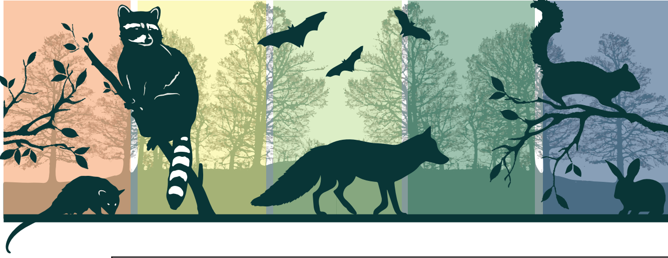


SILENT VOICES
WILDLIFE REHABILITATION

WILDLIFE INTAKE INFORMATION (* REQUIRED FIELD)

SPECIES: ______________________ GENDER: Male Female Unknown

DATE FOUND ______________________ * TIME FOUND ______________ AM / PM

HAS ANYONE BEEN BITTEN? YES NO

LOCATION ANIMAL WAS FOUND: ______________________

CITY: ______________________ STATE: LOUISIANA ZIP CODE: ______________

LIST ALL FOOD, MEDICATION, OR TREATMENTS GIVEN TO THE ANIMAL(S):

____

____

PRESENTER INFORMATION

NAME ______________________ PHONE NUMBER ______________________

ADDRESS ______________________

CITY ______________________ STATE ____ ZIP ______________

EMAIL ______________________

REASON FOR DROP-OFF (please check all that apply)

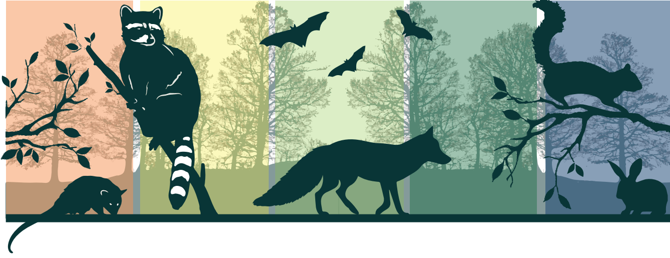
- [ ] Found on ground
- [ ] Fell from nest
- [ ] In the road
- [ ] Limping
- [ ] Caught by cat
- [ ] Hit window
- [ ] Shot
- [ ] Caught in fishing line/hook
- [ ] Orphaned (suspected)
- [ ] Other: ______________
- [ ] In a trap
- [ ] Nest destroyed
- [ ] Unable to stand
- [ ] Oiled
- [ ] Caught by dog
- [ ] Hit by car, mower, or weed eater
- [ ] Abnormal behavior/appears sick
- [ ] Orphaned (mother known dead)
- [ ] Unable to fly

- [ ] THIS ANIMAL(S) MAY BE RELEASED ON MY PROPERTY (check box)

Wildlife rehabilitators are a non-profit organizations that rely on donations to help purchase food, medical care, housing and supplies for this animal and others.
YES, I would like to make a contribution in the amount of $ ______________

______________________ Presenter Signature

______________________ Date



SILENT VOICES
WILDLIFE REHABILITATION

Rehab Permit # ____________________ Record # ________________ Date Admitted__________________

FOR INTERNAL USE ONLY

IF NOT ON SITE, SUB-PERMITTEE NAME ________________________ DATE RECEIVED ___________________

INTAKE EXAM

PATIENT ID: ______________________________ Exam date: _____________ Time: _____________ am/pm

Circle all that apply

Limping Drooling Problems standing/inability to stand Seizures Vomiting Enlarged pupils
Trouble holding head erect/Head tilt Labored breathing Unable to see or react to stimuli
Missing hair/fur Diarrhea Walking in circles Obvious wounds/bleeding Muscle twitching

Age: ________ weeks months years Neonate Infant Juvenile Sub-Adult Adult
Weight: ___________ Temp _________ Attitude: Alert Lethargic Non-responsive
Dehydration: Mild Moderate Severe BCS: Emaciated Underweight Normal Overweight

Ears/Mouth/Nares ____
CNS/Neurologic ____
Heart/Lungs ____
GI/Vent ____
Musculoskeletal ____
Fur/Skin/Feathers ____
Body ____
Arms/Wings ____
Legs/Feet ____
Additional Comments ____
Examined by: ____

DISPOSITION

Release Date/Type: ________ H/S Release location: ____

Euthanized Date: _________ Method: ___________________ Died in care/Date: ___________

Transferred Date: __________ Transferred To: ____

Reason for Transfer: Continued Care Education Release