

VETERINARY SURGERY CLINIC

[Clinic Address]
[Phone Number]
[License Number]

INVOICE

Date: _____
Invoice #: _____

CLIENT INFORMATION

Name: _____
Phone: _____
Address: _____

PATIENT (PET) INFORMATION

Name/ID: _____
Species/Breed: _____
Weight (kg): _____

Description of Service / Procedure	Qty/Hrs	Unit Price	Total
Pre-Anesthetic Blood Work / Exam			
Anesthesia Induction & Monitoring			
Surgical Procedure: _____			
Operating Room / Facility Fee			
Medications (Injectable / Take-home)			

Description of Service / Procedure	Qty/Hrs	Unit Price	Total
Hospitalization & Recovery Nursing			
Surgical Supplies / Consumables			

Subtotal: \$ _____

Tax: \$ _____

Total Amount: \$ _____

Surgeon: _____ Anesthetist: _____

Notes: Post-operative instructions provided. Follow-up appointment scheduled for: _____