

MVSSforpets@gmail.com www.MVSS.info (336) 580-4570

SURGICAL CONSENT & AUTHORIZATION for Anal Sacculectomy & Lymph Node Removal Surgery

Date:	Referrin	ng Hospital/Doctor:		
Pet's name:		Client's name:		
Pet's DOB:	Breed:		Sex: Male Female	Altered: Yes No
that my pet is su	spected to have ar	ges that I have been in Anal Sac Mass and I ent options, including	Enlarged Abdominal	
		al Sacculectomy surge on my pet by Dr Jenni	•	ymph Node
I unders	understand surgery will be on the: (Circle & initial) RIGHT LEFT			
	ction, wound heal	sociated with this proc ing complications, del		•
		fecal incontinence (ter ight AND left) sided su		ent) after
I unders	tand that a guara	ntee for outcome is no	ot possible and not b	peing provided.
I unders additional cost.	tand that biopsy s	samples will be submi	tted by your vetering	arian for
	_	ical margins are likely may be recommended		o the anatomic
I unders	tand that success	ful outcomes require	proper home care ar	nd restrictions.
	tand that my pet s itional pain contro	will be administered N ol.	locita (local anesthe	tic lasting up to
		and videos to be obta d/or website or social	~ -	se by MVSS for
	rmission for my po noval Surgery by D	et to have Anal Saccu Or Jennifer Hoch.	lectomy surgery and	l Abdominal
Client's signature	;	Client's phone num	nber Date	:
Clinic Staff, please fill in:				
-	emp: HR	. RR.	Confirm: Circle one R	ight Left Both