Jennifer Hoch, DVM
Diplomate ACVS

MVSS
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SURGICAL CONSENT & AUTHORIZATION for Arthrodesis Surgery

Date:_____ Referring Hospital:_____

Pet's name:_____ Client's name:_____

Pet's DOB:_____ Breed: _____ Sex: Male Female Altered: Yes No

_____ This document acknowledges that I have been informed by Dr. _____ that my pet has sustained a severe injury (hyperextension/luxation/fracture) to the joint. I have been informed of the treatment options, including surgery.

_____ I elect and consent for surgical arthrodesis and bone graft to be performed on my pet by Dr Jennifer Hoch, DACVS.

_____ I understand surgery will be on: (Circle & initial) RIGHT _____ LEFT_____

_____ I understand surgery will be on: (Circle & initial) CARPUS _____ TARSUS_____

_____ I understand the risks associated with this procedure that include anesthetic risk, hemorrhage, nerve damage, infection, implant failure, delayed healing, & very rarely death.

_____ I understand that this surgery has a lengthy recovery for 3-4 months without complications so the carpus (wrist) or tarsus (ankle) joint will fuse and heal completely.

_____ I understand that an additional bandage or splint will be necessary after surgery. This would require regular home care, monitoring, and bandage changes for proper healing.

_____ I understand that successful outcomes require proper home care and restrictions.

_____ I understand that guarantees are not being made regarding healing or outcome after surgery.

_____ I understand that if infection or implant failure occurs, additional procedures may be necessary that include culture, medications and surgery to remove the implants.

_____ I understand that my pet will be administered Nocita (local anesthetic lasting up to 72 hours) for additional pain control during surgery.

_____ I consent for photographs and videos to be obtained of my pet for use by MVSS for case presentations, monitoring, and/or website or social media.

I hereby grant permission for my pet to undergo Arthrodesis surgery by Dr Jennifer Hoch.

_____ _____ _____

Client's signature Client's phone number Date

Clinic Staff, please fill in:

Weight:_____ Temp:_____ HR:_____ RR:_____

Confirm Leg: Circle One LEFT RIGHT Confirm Joint: CARPUS/FRONT TARSUS/BACK