Jennifer Hoch, DVM
Diplomate ACVS

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SURGICAL CONSENT & AUTHORIZATION for Brachycephalic Upper Airway 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 is suspected to have Brachycephalic Upper Airway Syndrome (elongated soft palate, stenotic nares, everted laryngeal saccules). I have been informed of the treatment options, including surgery.

_____ I elect and consent for surgery to be performed (Resection of elongated palate, nares resection and removal of everted saccules, if present) on my pet by Dr Jennifer Hoch, DACVS.

_____ I understand the risks associated with this procedure that may include anesthetic risk, hemorrhage, infection, wound healing complications, pharyngeal swelling & death.

_____ I understand that excitement, excessive panting/barking can lead to swelling of the surgical site in the throat/pharynx. If difficulty breathing occurs, this will require emergency care and possible temporary tracheostomy. Sedatives will be prescribed to prevent this.

_____ I understand that there is no guarantee of success or resolution with surgery. Snoring may still occur. Long term lifestyle changes are still recommended for any Brachycephalic breed (avoiding heat outside).

_____ I understand that successful outcomes require proper home care and restrictions. I understand that no guarantees are being made.

_____ 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 have surgery by Dr Jennifer Hoch.

_____ _____ _____

Client's signature | Client's phone number | Date

Clinic Staff, please fill in:

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