

SURGICAL CONSENT & AUTHORIZATION for Cholecystectomy 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 Gallbladder disease and/or a Gallbladder Mucocele. I have been informed of the treatment options, including surgery.

_____ I elect and consent for Abdominal exploratory surgery for Cholecystectomy (gall bladder removal), ensuring bile duct patency, and liver biopsy surgery to be performed 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, implant failure, recurrence, pancreatitis (which could require prolonged hospitalization) & death. With this gallbladder surgery, the mortality rate is reported to be ~32%.

_____ I understand that biopsy and other lab tests (ie Culture) will be obtained and submitted for your veterinarian.

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

_____ I understand that no guarantees are being made for outcome or success.

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

_____ 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: _____