

SURGICAL CONSENT & AUTHORIZATION

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 _____ I have been informed of the treatment options, including surgery.

_____ I elect and consent for _____ surgery to be performed on my pet by Dr Jennifer Hoch, DACVS.

_____ *If applicable: Surgery will be performed on the: RIGHT _____ LEFT _____

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

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

_____ I understand that guarantees are not being made for outcome.

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

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

_____ 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: _____

Confirm Leg: Circle One LEFT RIGHT