Jennifer Hoch, DVM
Diplomate ACVS

MVSS
mobile veterinary surgical services

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

SURGICAL CONSENT & AUTHORIZATION for Fracture Repair

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 LEFT RIGHT ____ non-union fracture. I have been informed of the treatment options, including surgery.

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

________ I understand surgery will be on the: (Circle & initial) RIGHT ________ LEFT________

________ 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 an additional bandage or splint may be necessary after surgery. This would require regular home care, monitoring, and bandage changes for proper healing.

________ I understand that if the fracture involves the joint, osteoarthritis could be expected in the future. Weight management, supplements, and medications may be recommended. Intermittent lameness may occur.

________ 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. Non-union fractures have a higher complication for healing.

________ 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.

________ 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 fracture repair 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

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OPTIONAL LICK SLEEVE ORDER

Date:_________________ Referring Hospital/Doctor:_____________________________________

Pet's name:__________________________ Client's name:__________________________________

________ This document acknowledges that I have been informed that my pet is not permitted to lick or chew at the surgical incision. I have been informed of the treatment options, Lick Sleeve and Elizabethan collar (E-collar or "cone of shame").

________ The Lick Sleeve is an optional alternative to cover and protect the incision when the pet is supervised.

________ The incision should still be monitored at least once per day.

________ I CHOOSE TO PURCHASE THE LICK SLEEVE FOR MY PET FOR AN ADDITIONAL $100.

________ I DECLINE TO PURCHASE THE LICK SLEEVE FOR MY PET

________________________________ ________________________________ __________________
Client's signature Client's phone number Date

SIZE GUIDE

	WEIGHT (LBS)	WAIST SIZE (IN)	HEIGHT (IN)
S	20-30	13-18	14-18
M	30-50	15-22	16-20
L	50-80	20-28	18-24
XL	80-120	23-33	24-31.5