Jennifer Hoch, DVM
Diplomate ACVS

MVSS
mobile veterinary surgical services

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

# SURGICAL CONSENT & AUTHORIZATION for Lateral Suture Stabilization

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 a cranial cruciate ligament rupture (CCLR). I have been informed of the treatment options, including surgery.

________ I elect and consent for Lateral Suture Stabilization (extracapsular) surgery to be performed on my dog 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 the surgical success rate with Lateral Suture is reported for 80-90% of pets having a good to excellent long term outcome. If implant failure/loosening or infection occurs, recovery can be delayed and the need for implant removal surgery may be necessary (at additional cost). I understand that no guarantees can be given.

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

________ I understand that no guarantees are being given.

________ I understand that 50-60% of pets with a torn CCL will have the same problem in the opposite leg.

________ 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 Lateral Suture surgery by Dr Jennifer Hoch.

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

Clinic Staff, please fill in: Confirm Leg: Circle One LEFT RIGHT

Weight:______________________________ Temp:_________________ HR:_________________ RR:______________

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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 MEASURE IN ORDER:

| | 1. WAIST SIZE (IN) | 2. WEIGHT (LBS) | 3. HEIGHT* (IN) |
|---|---|---|---|
| XS | 10.5-16 | 12.5-20 | 9-15 |
| S | 13-18 | 20-30 | 14-18 |
| M | 14-20 | 30-50 | 16-20 |
| L | 20-28 | 50-80 | 18-24 |
| XL | 24-37.5 | 80-120 | 24-31.5 |

**FIT TIPS** *SLEEVE LENGTH IS TRIMMABLE WITHOUT FRAYING.
**IF IN BETWEEN SIZES PICK SMALLER, SNUG FIT.