

SURGICAL CONSENT & AUTHORIZATION for TPLO 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 a cranial cruciate ligament rupture (CCLR). I have been informed of the treatment options, including surgery.

_____ I elect and consent for TPLO (tibial plateau leveling osteotomy) 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 TPLO is reported for 93-95% of dogs having a good to excellent long term outcome. Complications can occur in 5-7% of cases. If infection occurs, recovery can be delayed and the need for implant removal surgery may be necessary (at additional cost). I understand that guarantees are not being given.

_____ I understand that successful outcomes require proper home care and restrictions. I understand that guarantees are not being made for outcome.

_____ I understand that 50-60% of dogs 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 undergo TPLO 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

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:

HEIGHT
Measure from the top of your dogs back down to the ankle/hock

WAIST
Just in front of your dog's hind legs measure around the skinniest point in your pets waist

	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.