Jennifer Hoch, DVM
Diplomate ACVS

MVSS
mobile veterinary surgical services

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SURGICAL CONSENT & AUTHORIZATION for VBO 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 bulla (middle ear) disease (severe infection, polyp, obstruction or mass/tumor). I have been informed of the treatment options, including surgery.

_____ I elect and consent for Ventral Bulla Osteotomy (VBO) surgery to be performed on my pet by Dr Jennifer Hoch, DACVS.

_____ Surgery will be performed on the: Initial correct side: RIGHT_____ LEFT_____

_____ I understand the risks associated with this procedure that may include anesthetic risk, hemorrhage, infection, abscess, fistula, wound healing complications, nerve damage, Horner's syndrome, death.

_____ This surgery is being performed on a contaminated or infected area (the ear), so the risk of infection and/or fistulous tract is higher.

_____ Horner's syndrome (head tilt, sunken eye, drooping eyelid, small pupil) is very common in cats after bulla and ear surgery. In most cases in resolves within 3-4 weeks, but can be permanent in 14% of cats.

_____ I understand that biopsy and other lab tests (ie Culture) will be obtained and submitted for your veterinarian. Antibiotics are often recommended for 6-8 weeks after surgery to resolve the deep bone infection.

_____ 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 the recommended Nocita (local anesthetic lasting up to 72 hours) for additional 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: Circle One LEFT RIGHT