

SURGICAL CONSENT & AUTHORIZATION for Achilles Tendon 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 _____ Achilles tendon (Common Calcaneal Tendon) rupture (partial or complete). I have been informed of the treatment options, including surgery.

_____ I elect and consent for surgical repair and/or reattachment of the Achilles tendon 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, recurrence, delayed healing, & very rarely death.

_____ I understand that a bandage and splint will be necessary after surgery for 8 weeks. This will require regular home care, monitoring, and bandage changes (every 1-2 weeks) for proper healing. Bandage wounds/sores are possible.

_____ I understand that successful outcomes require proper home care and restrictions. No guarantees are being made regarding healing or outcome after surgery.

_____ 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 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 undergo Achilles tendon repair surgery by Dr Jennifer Hoch.

Client's signature

Clinic Staff, please fill in:

Client's phone number

Date

Weight: _____ Temp: _____ HR: _____ RR: _____ Confirm Leg: LEFT RIGHT