Jennifer Hoch, DVM
Diplomate ACVS

MVSS
mobile veterinary surgical services

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SURGICAL CONSENT & AUTHORIZATION for Cleft Palate 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 has a cleft palate. I have been informed of the treatment options, including surgery.

_____ I elect and consent for cleft palate repair surgery to be performed on my pet by Dr Jennifer Hoch, DACVS.

_____ I understand the risks associated with this procedure that may include anesthetic risk, hemorrhage, infection, wound healing complications, aspiration pneumonia, recurrence & death.

_____ I understand that the primary complication of cleft palate surgery is recurrence. If this occurs, then revision surgery will be necessary.

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

_____ I understand that no guarantees are being made.

_____ 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: _____