Jennifer Hoch, DVM
Diplomate ACVS

MVSS
mobile veterinary surgical services

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

# SURGICAL CONSENT & AUTHORIZATION for Fracture Repair 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 sustained a _____ fracture. I have been informed of the treatment options, including surgery.

_____ I elect and consent for surgical fracture repair 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, delayed healing, & very rarely death.

_____ I understand that the injury/fracture is at the growth plate and could cause growth deformity.

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

_____ I understand that guarantees are not being made regarding healing or outcome after surgery.

_____ I understand that it is expected for the surgical pins to be removed at a later time after the fracture has healed. This will require an additional procedure with sedation/anesthesia for additional cost.

_____ 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 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 fracture repair surgery by Dr Jennifer Hoch.

_____ _____ _____

Client's signature Client's phone number Date

Clinic Staff, please fill in:

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

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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:

LICK SLEEVE


| | 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 |
| XXL | 27.5-45 | 120-190 | 27.5-43 |

## FIT TIPS

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