Jennifer Hoch, DVM
Diplomate ACVS

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SURGICAL CONSENT & AUTHORIZATION for Shoulder OCD Removal 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 Osteocondritis Dessicans (OCD) of the shoulder joint(s). I have been informed of the treatment options, including surgery.

_____ I elect and consent for an Open Arthrotomy (for removal of the OCD lesion and Curretage) 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, delayed healing, & very rarely death.

_____ I understand that the surgical success rate with OCD removal in the shoulder joint is reported for 75-85% of pets having a good to excellent long-term outcome.

_____ I understand that no guarantees can be given.

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

_____ I understand that osteoarthritis is still expected to develop long term. To prevent symptoms of arthritis, long term weight management is recommended. Other supplements and/or medications may be recommended in the future, as well.

_____ I understand that my pet will be administered 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 Shoulder OCD 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