Jennifer Hoch, DVM
Diplomate ACVS

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SURGICAL CONSENT & AUTHORIZATION for Splenectomy Surgery

Date:_____ Referring Hospital/Doctor:_____

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 abdominal disease and/or mass/lesion in the spleen. I have been informed of the treatment options, including surgery.

_____ I elect and consent for abdominal exploratory surgery for spleen removal (splenectomy) +/- liver biopsy to be performed on my pet by Dr Jennifer Hoch, DACVS.

_____ I understand the risks associated with this procedure that include anesthetic risk, hemorrhage, peritonitis, infection, ECG arrhthymias, wound healing complications, sepsis, DIC (disseminated intravascular coagulation, & death.

_____ I understand that biopsy samples obtained during surgery will be submitted for histopathology (analysis under the microscope by a pathologist) by my veterinarian. These biopsies may help provide a diagnosis.

_____ I understand that guarantees are not being made regarding my pet's recovery, diagnosis, or long-term survival.

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

_____ 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 have Abdominal Exploratory, Splenectomy, and Liver biopsy surgery by Dr Jennifer Hoch.

_____ _____ _____

Client's signature Client's phone number Date

Clinic Staff, please fill in:

Weight:_____ Temp:_____ HR:_____ RR:_____