Jennifer Hoch, DVM
Diplomate ACVS

MVSS
mobile veterinary surgical services

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SURGICAL CONSENT & AUTHORIZATION for Screw Tail Amputation 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 screw tail and secondary dermatitis. I have been informed of the treatment options, including surgery.

_____ I elect and consent for a Screw Tail Amputation surgery to be performed on my pet by Dr Jennifer Hoch, DACVS.

_____ I understand the risks associated with this procedure that include anesthetic risk, hemorrhage, infection, wound healing complications, dehiscence (opening of the incision), nerve damage, sepsis & death.

_____ I understand that a guarantee for outcome is not possible and not being provided.

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

_____ I understand that a culture sample will be collected during surgery for your veterinarian to submit for additional cost.

_____ 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 Screw Tail Amputation surgery by Dr Jennifer Hoch.

_____ _____ _____

Client's signature Client's phone number Date

Clinic Staff, please fill in:

Weight_____ Temp:_____ HR:_____ RR:_____