

Jennifer Hoch, DVM
Diplomate ACVS



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SURGICAL CONSENT & AUTHORIZATION for Revision 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 recurrence of _____ (after previous surgery). I have been informed of the treatment options, including surgery.

_____ I elect and consent for exploratory surgery of the left neck to be performed to remove any remaining affected/abnormal salivary tissue on my pet by Dr Jennifer Hoch, DACVS.

_____ *If applicable: Surgery will be performed on the: RIGHT_____ LEFT_____

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

_____ I understand that this is a revision surgery and will be more challenging due to previous scar tissue and inflammation. There is a higher chance of postoperative complications, infection and recurrence with each subsequent surgery.

_____ I understand that there is no guarantee of success or resolution with surgery.

_____ I understand that biopsy samples will be obtained and submitted by your veterinarian.

_____ I understand that successful outcomes require proper home care and restrictions. I understand that no guarantees are being made.

_____ 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 have surgery by Dr Jennifer Hoch.

Client's signature

Client's phone number

Date

Clinic Staff, please fill in:

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

Confirm: Circle One LEFT RIGHT