Jennifer Hoch, DVM
Diplomate ACVS

MVSS
mobile veterinary surgical services

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

SURGICAL CONSENT & AUTHORIZATION for Lateral Suture Stabilization

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 cranial cruciate ligament rupture (CCLR). I have been informed of the treatment options, including surgery.

_____ I elect and consent for Lateral Suture Stabilization (extracapsular) 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, implant failure, delayed healing, & very rarely death.

_____ I understand that the surgical success rate with Lateral Suture is reported for 80-90% of pets having a good to excellent long-term outcome. If implant failure/loosening or infection occurs, recovery can be delayed and the need for implant removal surgery may be necessary (at additional cost). I understand that no guarantees can be given.

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

_____ I understand that no guarantees are being given.

_____ I understand that 50-60% of pets with a torn CCL will have the same problem in the opposite leg.

_____ 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 Lateral Suture 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.