

Jennifer Hoch, DVM  
Diplomate ACVS



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## SURGICAL CONSENT & AUTHORIZATION for Abdominal 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. I have been informed of the treatment options, including surgery.

\_\_\_\_\_ I elect and consent for abdominal exploratory 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, peritonitis, infection, intestinal leakage, wound healing complications, sepsis & death.

\_\_\_\_\_ I understand that negative exploratory is possible.

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

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

\_\_\_\_\_ I elect for my pet to be administered Nocita (local anesthetic lasting up to 72 hours) for additional \$200. CIRCLE ONE: YES NO

\_\_\_\_\_ 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. CIRCLE ONE: YES NO

I hereby grant permission for my pet to have Abdominal Exploratory surgery by Dr Jennifer Hoch.

\_\_\_\_\_  
Client's signature

\_\_\_\_\_  
Client's phone number

\_\_\_\_\_  
Date

For Office Use Only:

Weight: \_\_\_\_\_ Temp: \_\_\_\_\_ HR: \_\_\_\_\_ RR: \_\_\_\_\_