Jennifer Hoch, DVM
Diplomate ACVS

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SURGICAL CONSENT & AUTHORIZATION for Achilles Tendon Repair

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 has sustained a LEFT______ RIGHT ______ Achilles tendon (Common Calcaneal Tendon) rupture (partial or complete). I have been informed of the treatment options, including surgery.

________ I elect and consent for surgical repair and/or reattachment of the Achilles tendon to be performed on my pet 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, recurrence, delayed healing, & very rarely death.

________ I understand that a bandage and splint will be necessary after surgery for 8 weeks. This will require regular home care, monitoring, and bandage changes (every 1-2 weeks) for proper healing. Bandage wounds/sores are possible.

________ I understand that successful outcomes require proper home care and restrictions. No guarantees are being made regarding healing or outcome after surgery.

________ I understand that if infection or implant failure occurs, additional procedures may be necessary that include culture, medications and surgery to remove the implants.

________ 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 undergo Achilles tendon repair 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