

## SURGICAL CONSENT & AUTHORIZATION for Cleft Palate 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 has a cleft palate. I have been informed of the treatment options, including surgery.

\_\_\_\_\_ I elect and consent for cleft palate repair surgery to be performed on my pet by Dr Jennifer Hoch, DACVS.

\_\_\_\_\_ I understand the risks associated with this procedure that may include anesthetic risk, hemorrhage, infection, wound healing complications, aspiration pneumonia, recurrence & death.

\_\_\_\_\_ I understand that the primary complication of cleft palate surgery is recurrence. If this occurs then revision surgery will be necessary.

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

\_\_\_\_\_ I understand that no guarantees are being made.

\_\_\_\_\_ 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: \_\_\_\_\_