Jennifer Hoch, DVM
Diplomate ACVS

MVSS
mobile veterinary surgical services

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

SURGICAL CONSENT & AUTHORIZATION for Fracture 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 Humeral Condylar fracture in the elbow. I have been informed of the treatment options, including surgery.

_____ I elect and consent for surgical fracture repair 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, delayed healing, & very rarely death.

_____ I understand that 100% of dogs will develop osteoarthritis on x-rays after this injury. This may cause continued intermittent or permanent lameness in the future or require medications.

_____ I understand that the injury/fracture is at the growth plate and could cause growth deformity.

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

_____ I understand that guarantees are not being made regarding healing or outcome after surgery.

_____ I understand that it is possible for the surgical pins to be removed at a later time after the fracture has healed. This will require an additional procedure with sedation/anesthesia for additional cost.

_____ 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 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 undergo fracture 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: Circle One 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

LICK SLEEVE

	WEIGHT (LBS)	WAIST SIZE (IN)	HEIGHT (IN)
S	20-30	13-18	14-18
M	30-50	15-22	16-20
L	50-80	20-28	18-24
XL	80-120	23-33	24-31.5