Jennifer Hoch, DVM Diplomate ACVS



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SURGICAL CONSENT & AUTHORIZATION for Fracture Repair

Date:	Referring I	Hospital:			
Pet's name:	et's name: Client's name:				
Pet's DOB:	Breed:		Sex: Male I	Female Altered: Yes No	
This docur that my pet has sus fracture. I have bee	stained a LEFT I	RIGHT		y Dr surgery.	
I elect and Jennifer Hoch, DAC		gical fracture 1	repair to be perfor	rmed on my pet by Dr	
I understa	nd surgery will b	oe on the: (Cir	cle & initial) RIGH	IT LEFT	
·			-	t include anesthetic risk, ling, & very rarely death.	
		_		necessary after surgery. nanges for proper healing.	
	it management,		•	rthritis could be expected may be recommended.	
I understa	nd that successi	ful outcomes r	equire proper hor	ne care and restrictions.	
I understar after surgery.	nd that guarant	ees are not be	ing made regardir	ng healing or outcome	
I understance be necessary that in		-	•	lditional procedures may ove the implants.	
I elect for r hours) for additiona	-		ita (local anesthet NO	tic lasting up to 72	
I consent for case presentations,			•	pet for use by MVSS for RCLE ONE: YES NO	
I hereby grant perm Hoch.	ission for my pe	et to undergo f	racture repair su	rgery by Dr Jennifer	
Client's signature		Client's pho	ne number	Date	
Office Use Only: Weight: Confirm Leg: Circle One	LEFT RIGHT	Temp:	HR:	RR:	