Jennifer Hoch, DVM
Diplomate ACVS

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SURGICAL CONSENT & AUTHORIZATION for Lateral Suture Stabilization

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 is suspected to have a cranial cruciate ligament rupture (CCLR). I have been informed of the treatment options, including surgery.

_____ I elect and consent for Lateral Suture Stabilization (extracapsular) surgery to be performed on my dog 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 the surgical success rate with Lateral Suture is reported for 80-90% of pets having a good to excellent long term outcome. If implant failure/loosening or infection occurs, recovery can be delayed and the need for implant removal surgery may be necessary (at additional cost). I understand that no guarantees can be given.

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

_____ I understand that no guarantees are being given.

_____ I understand that 50-60% of pets with a torn CCL will have the same problem in the opposite leg.

_____ 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. CIRCLE ONE: YES NO

I hereby grant permission for my pet to have Lateral Suture surgery by Dr Jennifer Hoch.

_____ _____ _____

Client's signature | Client's phone number | Date

For Office Use Only: Confirm Leg: Circle One LEFT RIGHT

Weight:_____ Temp:_____ HR:_____ RR:_____