Jennifer Hoch, DVM
Diplomate ACVS


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

# SURGICAL CONSENT & AUTHORIZATION for Laryngeal Arytenoid Lateralization Surgery

Date: _____ Referring Hospital/Doctor: _____

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 Laryngeal Paralysis. I have been informed of the treatment options, including surgery.

_____ I elect and consent for Laryngeal Arytenoid Lateralization 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, suture breakage, cartilage fracture, pharyngeal swelling & death.

_____ Aspiration pneumonia may occur in 30% of dogs after Laryngeal Arytenoid Lateralization (Tie-Back) surgery. This is a lifelong risk that is worse with anesthesia, sedation, vomiting and swimming. Aspiration pneumonia can be severe and fatal.

_____ I understand that excitement, excessive panting/barking can lead to swelling of the surgical site in the throat/pharynx. If difficulty breathing occurs, this will require emergency care and possible temporary tracheostomy. Sedatives will be prescribed to prevent this.

_____ I understand that there is no guarantee of success or resolution with surgery. Long term lifestyle changes are still recommended, such as avoiding heat outside.

_____ I understand that successful outcomes require proper home care and restrictions. I understand that no guarantees are being made.

_____ I understand that my pet will be administered Nocita (long-acting local anesthetic that lasts 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 have surgery by Dr Jennifer Hoch.

_____ _____ _____

Client's signature Client's phone number Date

Clinic Staff, please fill in:

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