Jennifer Hoch, DVM
Diplomate ACVS

MVSS
mobile veterinary surgical services

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

SURGICAL CONSENT & AUTHORIZATION for Perineal Urethrostomy 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 is suspected to have feline lower urinary tract disease. I have been informed of the treatment options, including surgery.

_____ I elect and consent for Perineal Urethrostomy surgery to be performed on my pet by Dr Jennifer Hoch, DACVS. This creates a new, larger opening for your pet to urinate and allow small stones to pass.

_____ I understand the risks associated with this procedure that include anesthetic risk, hemorrhage, infection, urine leakage, wound healing complications, stricture formation, sepsis & death.

_____ Lab tests for urine culture may be submitted by your veterinarian for additional cost.

_____ I understand that successful outcomes require proper home care and restrictions. The Elizabethan collar MUST be worn AT ALL TIMES for 2-3 weeks after surgery.

_____I understand that guarantees are not being made about final outcome.

_____ Urinary tract infections can continue long term recommendations will be made by your veterinarian to attempt to prevent stone recurrence (special diet, water, etc)

_____ I understand that my pet will be administered Nocita (local anesthetic lasting 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 Perineal Urethrostomy by Dr Jennifer Hoch.

_____ _____ _____

Client's signature Client's phone number Date

Clinic Staff, please fill in:

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