Jennifer Hoch, DVM
Diplomate ACVS

MVSS
mobile veterinary surgical services

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

SURGICAL CONSENT & AUTHORIZATION for MPL 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 a medially luxating patella (MPL). I have been informed of the treatment options, including surgery.

_____ I elect and consent for MPL correction (trochlear wedge recession, lateral imbrication, medial fascial release and tibial tuberosity transposition) 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, reluxation of the patella & very rarely death.

_____ I understand that the surgical success rate with MPL surgery for Grade 2-3 is reported for 90-95% of dogs and cats having a good to excellent long-term outcome. Complications can occur in up to 10% of cases and may include reluxation of the patella (coming out of place again) and pin loosening (requiring pin removal in the future). Grade 4 MPL have a higher complication rate of 30%, including reluxation and the need for another surgery.

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

_____ I understand that no guarantees are being given.

_____ 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 MPL 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; or for the Bilateral (both legs) Suit for $130.

_____ I DECLINE TO PURCHASE THE LICK SLEEVE FOR MY PET.

_____ _____ _____

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

Reversible Single Lick Sleeve
$100

Bilateral (Both Legs) Lick Sleeve Suit
$130