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SURGICAL CONSENT & AUTHORIZATION for Fracture Repair 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 has sustained a _____ fracture. I have been informed of the treatment options, including surgery.

_____ I elect and consent for surgical fracture repair to be performed on my pet 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 an additional bandage or splint may be necessary after surgery. This would require regular home care, monitoring, and bandage changes for proper healing.

_____ I understand that if the fracture involves the joint, osteoarthritis could be expected in the future. Weight management, supplements, and medications may be recommended. Intermittent lameness may occur.

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

_____ I understand that guarantees are not being made regarding healing or outcome after surgery.

_____ I understand that if infection or implant failure occurs, additional procedures may be necessary that include culture, medications and surgery to remove the implants.

_____ I understand that my pet will be administered Nocita (local anesthetic lasting up to 72 hours) for additional pain control during surgery.

_____ 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 fracture repair 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

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.

_____ I DECLINE TO PURCHASE THE LICK SLEEVE FOR MY PET

Client's signature

Client's phone number

Date

SIZE GUIDE

MEASURE IN ORDER:



XS
S
M
L
XL
XXL

1. WAIST SIZE (IN)

10.5-16
13-18
14-20
20-28
24-37.5
27.5-45

2. WEIGHT (LBS)

12.5-20
20-30
30-50
50-80
80-120
120-190

3. HEIGHT* (IN)

9-15
14-18
16-20
18-24
24-31.5
27.5-43

FIT TIPS

***SLEEVE LENGTH IS TRIMMABLE WITHOUT FRAYING.**
****IF IN BETWEEN SIZES PICK SMALLER, SNUG FIT.**