SURGICAL CONSENT & AUTHORIZATION (Extracapsular Suture)

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 (CrCL) rupture. I have been informed of the treatment options, including surgery.

_____ I elect and consent for Extracapsular Suture Stabilization surgery to be performed on my dog by Dr. Jessie Sutton, DACVS-SA.

_____ 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 Extracapsular Suture is reported that 80- 90% of pets have a good to excellent long term outcome. If implant failure/loosening or infection occurs, recovery can be delayed and additional surgery may be necessary (at additional cost).

_____ 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 CrCL will experience 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 Roam Veterinary Surgery for case presentations, monitoring, and/or website or social media. CIRCLE ONE: YES NO

I hereby grant permission for my pet to undergo Extracapsular Suture Stabilization surgery by Dr. Jessie Sutton, DACVS-SA.

_____ _____ _____

Client's signature Client's phone number Date