SURGICAL CONSENT & AUTHORIZATION (Sialoadenectomy)

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 salivary gland problem (sialocele/salivary mucocele or ranula). I have been informed of the treatment options, including surgery.

_____ I elect and consent for exploratory surgery and salivary gland removal surgery to be performed on my pet by Dr Jessie Sutton, DACVS-SA.

_____ *If applicable: Surgery will be performed on the: RIGHT_____ LEFT_____

_____ I understand the risks associated with this procedure that may include anesthetic risk, hemorrhage, infection, wound healing complications, recurrence (~5-15% risk following surgery) & death

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

_____ I understand that my pet may 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 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 have surgery by Dr. Jessie Sutton

_____ _____ _____

Client's signature Client's phone number Date