SYNERGY

MOBILE VETERINARY SURGERY

Surgical Consent Form for Lateral Suture Stabilization (Extracapsular repair)

Owner name: _____ Pet Name: _____
Veterinary Hospital: _____
Primary veterinarian: _____
Patient age: _____ Breed: _____
Patient sex: M MN F FS

_____ I have been notified of the diagnosis of a suspect cranial cruciate ligament injury by Dr. _____ and informed of the different surgical and non surgical treatment options

_____ Surgery will be on the: Right_____ Left_____ (Please initial)

_____ I am aware that the prognosis for cruciateL\ surgery is usually excellent. I understand that, while the prognosis is excellent, guarantees are not being given. If implant migration or infection occurs, recovery can be delayed and implant removal may be recommended and further costs may be incurred.

_____I have been informed that over 50% of pets will develop cruciate disease in the opposite limb within their lifetime

_____ Possible complications are uncommon but can include: anesthesia risks (including - very rarely - possible death), infection, nerve injury, hemorrhage, swelling and bruising, implant failure, fracture of the tibia

_____ Implant shifting or breakage can delay recovery

_____ Abiding by the post operative instructions is crucial for a proper recovery and to help avoid some of the above listed complications. Some of these complications will delay recovery and may necessitate further surgical intervention and expense

_____ I give consent to Dr. Cindy Eward or Dr. Marc Hirshenson of Synergy Mobile Veterinary Surgery to perform an extracapsular stabilization on my pet

Y / N I consent to photographs/video of my pet to be used by Synergy Mobile Veterinary Surgery for continuing education lectures, monitoring, case documentation and social media

_____ _____ _____
Client Signature Client Phone number Date

Office Use Only:
Weight (kg): _____ Temp: _____ HR: _____ RR: _____

Confirm leg: LEFT RIGHT