VETERINARY roam ATX SURGERY

Surgical Consent & Authorization
Gastrointestinal Surgery

Date: _____ Referring Hospital: _____

Pet's Name: _____ Client's name: _____

Pet's DOB: _____ Breed: _____ Sex: Male / Female Neutered: Yes / No

_____ This document acknowledges that I have been informed by Dr. _____ that my pet is suspected to have a gastric/small intestinal _____. I have been informed of the treatment options, including surgery.

_____ I elect and consent for abdominal exploratory surgery to be performed on my pet by Dr. Krista Adamovich, DACVS-SA.

_____ I understand the risks associated with this procedure that **may include:** anesthetic risk, hemorrhage (bleeding), peritonitis (abdominal infection), incisional infection, intestinal leakage, wound healing complications, sepsis & death.

_____ I understand that intestinal surgery is associated with a 5-10% risk of dehiscence (leakage from the intestinal surgery site). If this complication occurs it is most likely to happen 3-5 days following surgery. This complication is life-threatening and requires emergency treatment and additional surgery.

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

_____ I understand that a guarantee for outcome is not possible and not being provided.

_____ I understand that my pet may be administered Nocita (local anesthetic lasting up to 72 hours) for additional pain control. *Pending primary care DVM authorization & available supply.*

_____ I consent for photographs and videos to be obtained of my pet for use by Roam ATX 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 abdominal exploratory surgery by Dr. Krista Adamovich, DACVS-SA.

_____ _____ _____

Client's Signature Client's Phone Number Date