

Surgical Consent & Authorization Splenectomy

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 mass or lesion affecting the spleen. I have been informed of the treatment options, including surgery.

_____ I elect and consent for abdominal exploratory surgery for spleen removal (splenectomy) +/- liver biopsy 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, infection, wound healing complications, hemorrhage (blood loss, potentially necessitating a blood transfusion), ECG arrhythmias, DIC (disseminated intravascular coagulation), and sudden death.

_____ I understand a diagnosis of cancer is possible in **at least** 50% of cases of splenic masses. Splenic cancer often carries a poor long-term survival rate, often with patients living only a few months beyond surgery.

_____ I understand that biopsy samples obtained during surgery will be submitted for histopathology (analysis under the microscope by a pathologist) by my veterinarian.

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

_____ I understand that there is no guarantee of success or resolution with surgery.

_____ 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 surgery performed by Dr. Krista Adamovich, DACVS-SA.

Client's Signature

Client's Phone Number

Date

