

Surgical Consent & Authorization Perineal Urethrostomy

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 _____. I have been informed of the treatment options, including surgery.

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

_____ Surgery will be performed on the perineum, scrotum and penis.

_____ I understand the risks associated with this procedure that **may include:** urethral structure, recurrent urinary tract infections, anesthetic risk, hemorrhage (bleeding), infection, wound healing complications, recurrence & death.

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

_____ I understand that no guarantees are being made regarding the outcome.

_____ 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

