VETERINARY roam ATX SURGERY

Surgical Consent & Authorization
Patella Luxation

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

_____ I elect and consent for patella luxation corrective surgery (trochleoplasty, medial release, lateral imbrication, +/- tibial tuberosity transposition) to be performed on my pet by Dr. Krista Adamovich, DACVS-SA.

_____ I understand surgery will be performed on the:
(Circle & Initial) RIGHT _____ / LEFT _____ / BILATERAL _____

_____ I understand the risks associated with this procedure that **may include:** anesthetic risk, hemorrhage (bleeding), nerve damage, infection, implant failure or migration, delayed healing, reluxation of the patella & very rarely death.

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

_____ I understand that guarantees are not being made regarding healing or outcome after surgery.

_____ I understand that my pet will be administered Nocita (local anesthetic lasting up to 72 hours) for additional pain control.

_____ 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 patella luxation surgery by Dr. Krista Adamovich, DACVS-SA.

_____ _____ _____

Client's Signature Client's Phone Number Date