Elective Surgery Consent

Owner’s Name ____________________________________________

Pet’s Name ____________________________________________

Animal Hospital/Attending Clinician __________________________

Surgical Procedure (if applicable, MUST include which limb) ________________

My Phone Number(s) Today _________________________________

I have been advised as to the nature of the surgery described above and the risks involved. I authorize, Dr. Rebecca Tudor, DACVS or Dr. Elizabeth Taylor, DACVS to perform this surgery. I also understand that the above clinic/hospital (with assistance of the TVSS team as needed) will be using appropriate anesthetics and medications needed to perform this surgical procedure and will be responsible for monitoring my pet.

Signature ___________________________ Date ____________________

Witness _________________________________

***If this form is not complete, the surgery will have to be rescheduled***

_____ Yes, I give TVSS permission to use my pet’s picture/video & first name on TVSS social media sites

_____ No, I do not give TVSS permission to use my pet’s picture/video & first name on TVSS social medial sites