



# VOST

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SURGERY

Visiting Orthopaedic and Soft  
Tissue Surgery

## Surgery Consent Form

Date of Surgery \_\_\_\_\_

Client name \_\_\_\_\_

Patient name \_\_\_\_\_

Procedure \_\_\_\_\_

Contact Telephone number \_\_\_\_\_

Other known medical Issues \_\_\_\_\_

Current Medication	Last dose administered

Please circle Yes/No to the questions below:

I have read the information sheet regarding the surgery and/or have had the procedure explained to me including aftercare.	Yes/No
I have made provisions for crate restriction if advised.	Yes/No
I have had the most common complications and risks of surgery explained to me.	Yes/No
I give permission for anonymous data or images (diagnostic images, photos from surgery or history) to be used for auditing, teaching or publication purposes.	Yes/No

Signed.....

Print Name.....

Date.....