Orthopaedic and Spine Institute
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DISCLOSURE AND CONSENT

Medical and Surgical Procedures

TO THE PATIENT*: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (we) voluntarily request Orthopaedic and Spine Institute as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as: _____
_____
_____

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures_____
_____
_____

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) (do) (do not) consent to the use of blood and blood products as deemed necessary. Risks related to the use of blood products are: fever, transfusion reaction which may include kidney failure or anemia; heart failure; Human Immunodeficiency Virus (1 in 677,000 units); Hepatitis B virus (1 in 63,000 units); Hepatitis C virus (1 in 103,000 units); Cytomegalovirus (less than 1 in 698 units, most adults are not susceptible); Febrile reaction (0.5 – 1% with red blood cells, 1.6-37.5% with platelets); Urticarial reaction (1-3% frequency); Hemolytic reaction (1 in 12,000-25,000 units); Anaphylactic reaction (1 in 20,000 – 170,000 units); other infections.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for

infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure include but are not limited to: impaired function/growth deformity; blood vessel or nerve injury; pain or discomfort; fat escaping from bone with possible damage to vital organs; failure of bone to heal; bone infection; possible need for removal or replacement of any implanted device or material; failure of surgery to work; continued loosening of the joint; degenerative arthritis; increased stiffness; persistent or worsening numbness and/or tingling; impaired muscle function; recurrence or persistence of the condition that required the operation; continued, increased, or different pain; late tendon rupture; loss of motion; neuroma formation; need for further surgery.

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us). I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required):

Signature

Name of Patient (Last, First, Middle Initial)

DATE: _____ TIME: _____ A.M./P.M.

_____

Address of Patient(Street or P. O. Box)

_____

City, State, Zip Code

WITNESS:

_____

Signature

_____

Name (Print)

COUNSELING PHYSICIAN:

Signature

Name (Print)