
Progressive Surgical Associates

INFORMED CONSENT FOR ANTERIOR APPROACH FOR SPINE SURGERY

It is very important to us that you understand and consent to the treatment your doctor is providing and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended.

Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

Patient's Initials or Authorized Representative

Date

I, _____, hereby authorize Dr. _____ and any associates or assistants the doctor deems appropriate, to perform upon me anterior approach for spine surgery.

The doctor has explained to me the potential benefits of surgery. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well-being, and safety.

The doctor has explained to me that there are risks and possible undesirable consequences associated with the procedure including, but not limited to, bleeding, infection, injury to other organs, blood vessels, ureter(s), or bladder, temporary paralysis of small or large bowel, blood clots, hernia, sexual dysfunction, acute/chronic disability, stroke, nerve damage, obstruction of the bowel, infection, heart complications, permanent disability and death. I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis, or other diseases. Further, any of these risks or complications may require further surgical intervention during or after the procedure, which I expressly authorize. _____
initial

In permitting my doctor to perform the procedure, I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his/her assistants, or his/her designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.

In the unlikely event that one or more of the above inherent complications may occur, my physician or covering physician will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

The reasonable alternatives to the procedure have been explained to me. These alternatives vary depending on the underlying condition and may include but are not limited to, drug treatment of inflammatory bowel disease, attempted obstruction removal, and chemotherapy and/or radiation. I understand that these alternatives may be ineffective or significantly less effective than my prescribed treatment.

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USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

_____ Foreign language (specify)

_____ Sign language

_____ Patient is blind, form read to patient

_____ Other (specify) _____

Interpretation provided by _____
(Fill in name of Interpreter and Title or Relationship to Patient)

Signature (Individual Providing Assistance)

_____/_____
Date Time