



Affix Patient Label

Patient Name:

Date of Birth:

Informed Consent: Thoracic, Lumbar, and/or Sacral Fusion Surgery

This information is given to you so that you can make an informed decision about having **surgery on your thoracic, lumbar, and/or sacral spine.**

Reason and Purpose of this Procedure:

Surgery on my thoracic, lumbar, and/or sacral spine is done to:

- Relieve pain, numbness, tingling or weakness.
- Restore nerve function.
- Stop abnormal motion of the spine.
- Correct deformity or realign spine.

Fusion Done in the Front of the Spine:

The surgeon removes the disc (the cushion between your vertebrae). A metal or plastic spacer (“cage”) is placed between the vertebrae and filled with bone graft. Metal plates and screws may be used with the cage to hold it in place and keep the bones from moving while the bone heals. This is called "instrumentation." Overtime, the bone graft fuses to the surrounding bones and stops motion.

Fusion Done in the Back or Side of the Spine:

The surgeon removes bone or other tissues that are pressing on the nerve roots. Sometimes a metal or plastic spacer (“cage”) is placed between the vertebrae and filled with bone graft. Metal screws and wires rods are used with bone graft to keep the bones from moving while the bone heals. This is called “instrumentation”. Over time, the bone graft fuses to the surrounding bones and stops motion.

Benefits of this Procedure:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Relief or decrease of pain, numbness, tingling, or weakness in the legs and hips, and sometimes pain in the low back.
- Increased function during normal activities.
- You may be able to reduce or end the need for pain medication.

General Risks of Procedures:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

- Small areas of the lungs may collapse. This would increase the risk of infection. This may need antibiotics and breathing treatments.
- Clots may form in the legs, with pain and swelling. These are called DVTs or deep vein thromboses. Rarely, part of the clot may break off and go to the lungs. This can be fatal.
- A strain on the heart or a stroke.
- Bleeding may occur. If excessive you may need a blood transfusion.
- Reaction to the anesthetic. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you.

Risks of this Procedure:

- **Approach risks.** There is a slight chance of injury to the bowel, arteries, veins, and ureter (the connection between the kidney and the bladder).
- **Failure to relieve symptoms.** There is a chance that the surgery will not relieve the pain, numbness, tingling, weakness, or

other symptoms. You may need additional surgery.

- **Increased pain.** Pain or other symptoms may get worse after this procedure.
- **Infection.** Infection may occur in the wound, either near the surface or deep within the tissues. This could include the bone. You may need antibiotics or further treatment.
- **Nerve root injury.** Injury to the nerve roots may cause arm pain, paralysis in the affected muscle group or loss of feeling in the affected area.
- **Recurrence.** There is a chance that pain, numbness, tingling, weakness, or other symptoms may come back. You may need more surgery.
- **(Anterior fusions only) Retrograde ejaculation.** In males, small nerves may be injured causing sperm to go into the bladder instead out of the penis. This could cause problems having children.
- **Spinal cord injury.** There is a small risk of injury to the spinal cord. This could mean you would be paralyzed. Your bowel or bladder may not work correctly or at all.
- **Spinal fluid leakage.** A spinal fluid leakage may cause a spinal headache or need more surgery. You may need a procedure to fix this.

Risks Related to Fusion or Instrumentation:

Sometimes metal plates, rods, screws, or wires are used to stabilize the spine. This is called “instrumentation”.

- **Adjacent level stenosis.** There is a small chance that fusing one level will speed up the wear at another spine level. You may need additional treatment or even surgery in the future.
- **Extrusion of the bone graft.** The bone graft may move out of position. You may need more surgery to correct this.
- **Failure of the fusion.** The bone graft may not form a solid fusion. This could lead to spine deformity and pain and you may need more surgery.
- **Loosening and movement of instrumentation (the screws and/or plate(s)).** You may need surgery.
- **Fusion (allograft) risks.** Donor bone carries an extremely small risk of infection or disease transmission. There is a slightly greater risk that the bone fusion will fail.
- **Fusion (autograft) risks.** Bone removal from the pelvis can lead to chronic pain, nerve damage in the thigh and buttocks, or changes in how you walk.

Risks Associated with Smoking:

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and blood clot formation. Smoking has also been shown to slow down or stop the bone fusion.

Risks Associated with Obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and blood clot formation.

Risks Associated with Diabetes or Immune System Compromise:

The risk of infection, slow wound healing and slow bone healing (fusion) are increased in patients with:

- Diabetes
- Chemotherapy or radiation therapy
- AIDS
- Steroid use

Risks Specific to You:

Alternative Treatments:

Other choices:

- Physical or Occupational Therapy
- Massage Therapy
- Steroid injections.
- Pain Management
- Do nothing. You can decide not to have the procedure.

If you Choose not to have this Treatment:

- Your doctor can discuss alternative treatments with you.

General Information:

During this procedure, the doctor may need to perform more or different procedures than I agreed to.

During the procedure, the doctor may need to do more tests or treatment.

Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.

Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.

Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

Medical Implants/Explants:

I agree to release my social security number, my name and address, and my date of birth to the company that makes the medical device that is put in or removed during this procedure. Federal laws and rules require this. The company will use this information to locate me.



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By signing this form, I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure:
 - Anterior Lumbar Interbody Fusion/Anterior Spinal Fusion Surgery from the _____ lumbar vertebra through the _____ lumbar sacral vertebra.
 - Oblique Lumbar Interbody Fusion Surgery from the _____ lumbar vertebra through the _____ lumbar vertebra with percutaneous screws from the _____ lumbar to the _____ lumbar vertebra.
 - Transforaminal Lumbar Interbody Fusion Surgery from the _____ lumbar vertebra through the _____ lumbar sacral vertebra minimally invasive.
 - Posterior Spinal Fusion Surgery from the _____ thoracic lumbar vertebra through the _____ thoracic lumbar sacral vertebra pelvis.
 - with decompression from the _____ thoracic lumbar vertebra through the _____ thoracic lumbar sacral vertebra.
 - Sacroiliac fusion | Right Left Bilateral.
 - _____.
- I understand that my doctor may ask a partner to do the procedure.
- I understand that other doctors, including medical residents or other staff may help with procedure. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to procedure. If so, please obtain consent for blood/products.

Patient Signature: _____ Date: _____ Time: _____

Relationship: Patient Closest relative (relationship) _____ Guardian/POA Healthcare

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back:

Patient shows understanding by stating in his or her own words:

_____ Reason(s) for the treatment/procedure: _____

_____ Area(s) of the body that will be affected: _____

_____ Benefit(s) of the procedure: _____

_____ Risk(s) of the procedure: _____

_____ Alternative(s) to the procedure: _____

OR

_____ Patient elects not to proceed: _____ Date: _____ Time: _____

(Patient signature)

Validated/Witness: _____ Date: _____ Time: _____