BRONSON	Affix Patient Label
	Patient Name: Date of Birth:

Posterior Cervical Forminotomy Consent

This information is given to you so that you can make an informed decision about having surgery on your lumbar spine.

Reason and Purpose of the Procedure: Surgery on my cervical spine is done to:

- Relieve pain, numbness, tingling or weakness
- Restore nerve function

During this procedure all or part of the damaged disc in your neck is removed, or the space that the nerves travel through is widened, releasing pressure on nerves in your neck.

Benefits of this surgery

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 and weakness in the legs and hips, and sometimes in the lower-back area
- Increased function during normal activities
- You may be able to reduce or end the need for pain medication

Risks of Surgery

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.

General Risks of Surgery

- 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 thrombosis. 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 surgery

- **Failure to relieve symptoms**. There is a chance that the surgery will not relieve the pain, numbness, weakness or other symptoms. You may need more 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, weakness or other symptoms may come back. This may need more surgery.
- **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.
- **Stroke.** There is a small chance that the vertebral artery is damaged and may lead to a stroke. This may lead to more testing, surgery, and treatment for stroke.

Risks Associated with Smoking

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and 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 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:

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

Risks Specific to You

_____

_____

_____

_____

Alternative Treatments

Other choices:

- Medication for relief of pain or muscle spasms
- Physical or Occupational Therapy
- Massage Therapy
- Chiropractic manipulation
- Acupuncture
- 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: **Posterior Cervical Forminotomy_____**
- I understand that other doctors, including medical residents, or other staff may help with surgery. 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 surgery. IF so, please obtain consent for blood/product.

Patient Signature_____Date:_____Time:_____
Relationship: □Patient □Closest relative (relationship)_____ □Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.
Interpreter:_____Date_____Time_____
Interpreter (if applicable)

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: _____ (patient signature**)**

Validated/Witness:_____Date:_____Time:_____