BRONSON	Affix Patient Label
	Patient Name: Date of Birth:

This information is given to you so that you can make an informed decision about having **Suboccipital Craniectomy with or without Cervical Laminectomy for Chiari Malformation Adult.**

Reason and Purpose of the Procedure:
A **suboccipital craniectomy** is an operation where an opening is made in the skull, or cranium. A **Chiari malformation** occurs when the lower lobes of the brain (cerebellum) and sometimes brain stem are pushed against and through the hole in the bottom of the skull (foramen magnum). The goal of this procedure is to:

- Make the hole in the bottom of the skull larger
- Give the cerebellum and brain stem more space
- Allow for better flow of cerebral spinal fluid (liquid around the brain and spinal cord)

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.

- Headache and vision problems may go away
- Problems with balance and dizziness may get better
- Flow of cerebral spinal fluid may be restored

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:
The risks of a craniotomy from trauma are directly related to the severity of the injury.

- **Brain injury.** This procedure could cause injury to the surrounding brain.
- **Death.** Death may occur during or soon after surgery.
- **Failure of the procedure.** Your condition may not improve.
- **Functional loss.** You may have problems chewing after surgery. You may have problems with strength, sensation, speech and language, memory, hearing or vision after surgery.
- **Hemorrhage.** Bleeding in the brain rarely occurs and may require further surgery.
- **Hydrocephalus.** The normal flow of spinal fluid around the brain may change. This may need more treatment, including surgery.
- **Increased pain**. Pain or other symptoms may get worse after this procedure. You may have a headache for up to a month after surgery and occasionally for a longer period of time

- **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.
- **Neurologic decline.** You may have weakness, numbness, and speech and memory problems after surgery**.** This could be from hemorrhage (bleeding) or cerebral edema (buildup of fluid that results in swelling and pressure on the brain).
- **Seizure activity**. You may develop seizures.
- **Spinal fluid leakage**. A spinal fluid leakage may cause a spinal headache or need more surgery.

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.

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 Specific to You:

_____
_____
_____
_____

Alternative Treatments:
Other choices:

- Medicines may help with some symptoms such as headache.
- Observation with neurological exams and imaging (CAT scan or MRI).
- Do nothing. You can decide not to have the procedure.

If You Choose Not to Have this Treatment:

- You may choose the alternative treatments listed above.
- Your neurological function may decrease. Herniation (when the brain swells more than the skull can hold) may occur.
- The injury or hematoma may cause seizure activity.
- The trauma or hematoma may eventually cause death.

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.

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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: **Suboccipital craniectomy with or without cervical laminectomy for Chiari Malformation.**
  Location:_____
  _____
- I understand that my doctor may ask a partner to do the surgery.
- 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:_____