Affix Patient Label

Patient Name: Date of Birth:

Informed Consent: Hip Arthroplasty Surgery

This information is given to you so that you can make an informed decision about having **hip arthroplasty surgery.**

Reason and Purpose of this Procedure:

A hip replacement (or hip arthroplasty) is an operation done to treat the pain and stiffness associated with arthritis of the hip. It can also be performed for other conditions including avascular necrosis and fractures of the hip. The damaged ball of the hip is removed and replaced with metal, plastic or ceramic joint surfaces to restore the function of your hip. The goal of the hip replacement is to:

- Reduce pain
- Improve function

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.

- Reduced pain
- Improved function during normal activities
- Improved quality of life
- You may be able to reduce 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.
- **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 these with you.

Risks of this Procedure:

- **Infections are rare, but serious when they occur.** They can require additional surgery and antibiotics to treat. Sometimes the new hip needs to be removed to cure the infection.
- **The device can loosen or wear over time.** This can become painful and require additional surgery to treat the problem.
- **The device can dislocate.** This can be painful and require hospitalization to relocate the device.
- **Leg length differences can occur and are usually minor.** Major differences can require a lift in your shoe.
- **Damage to nerves and arteries can occur.** Nerve damage can cause numbness or weakness in the leg. Artery damage can cause excessive bleeding and require repair.
- **Fracture.** A fracture may occur during the surgery when the bone is prepared for the hip implants.
- **Blood clots. 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.
- **Failure to relieve symptoms.** There is a chance that the surgery will not relieve the pain or stiffness in your hip.

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 Associated with Diabetes:

Diabetes can increase the risk of infection, slow wound healing and slow bone healing.

Risks Specific to You:

____

____

____

____

Alternative Treatments:

Other choices:

- Do nothing. You can decide not to have the procedure.
- Pain management (medications)
- Steroid injections
- Physical Therapy

If you Choose not to have this Treatment:

- Your doctor can discuss the 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:

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.

Affix Patient Label

Patient Name: Date of Birth:

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: **Hip Arthroplasty Surgery | ☐ Left ☐ Right**
  ☐ Total ☐ Birmingham Hip Resurfacing ☐ Partial ☐ Revision

  ____

  ____
- 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: __________