Affix Patient Label	
Patient Name:	Date of Birth:

Informed Consent: Rotator Cuff Repair Surgery

This information is given to you so that you can make an informed decision about having either an **arthroscopic or open rotator cuff repair surgery**.

Reason and Purpose of the Procedure:

Rotator cuff repair surgery is a procedure done to treat pain and weakness of the shoulder. It may be done by an arthroscopic technique by using small instruments and video equipment through very small incisions or by an open incision. This may include repair of the rotator cuff tendons, removal of impinging bone spurs and bursitis, debridement or repair of the labrum (cartilage tissue), tenotomy (to cut) or tenodesis (to tack down) the long head of the biceps tendon, removal of loose bodies or shaving of lesions on the moving surfaces of the shoulder.

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.

- Reduced pain.
- Improved function during normal activities.
- Improved quality of life.
- You may also be able to resume more demanding physical activities.

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.
- A strain on the heart or a stroke may occur.
- Bleeding may occur. If bleeding is excessive, you may need a transfusion (this is very rare).
- Reaction to the anesthetic may occur. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesia provider will discuss this with you.

Risks of this surgery:

- **Infections are rare, but serious when they occur**. Treating infections can require antibiotics, and sometimes additional surgery.
- **Damage to nerves and arteries can occur**. Nerve damage can cause numbness or weakness in the arm. Artery damage can cause excessive bleeding and require repair.
- **Blood clots**. Blood clots may form causing pain and swelling. These are called deep vein thrombosis or DVT. 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 weakness in your shoulder.
- **Damage to the deltoid muscle can occur**. This may cause permanent weakness and cause pain in the shoulder.

Risks associated with smoking:

Smoking is linked to an increased risk of infections and DVT formation. Both can be serious complications.

Risks associated with obesity:

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

Risks associated with diabetes:

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

Risks specific to you:

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____

____

____

Alternative Treatments:

- Do nothing. You may decide not to have the procedure.
- Pain management (medications)
- Steroid injections
- Activity modification (avoid activities that make pain or other symptoms worse)

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.

I understand that in the event of an emergency my doctor may ask a partner to do the surgery.

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.

BRONSON

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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: ☐ **Shoulder Rotator Cuff Repair** ☐ **Shoulder Arthroscopy**________________
  ____
- 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 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/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: ____________