	Affix Patient Label
	Patient Name: Date of Birth:

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

Reason and Purpose of the Procedure:
During a suboccipital craniectomy an opening is made in the skull, or cranium. A Chiari malformation happens when the lower lobes of the brain (cerebellum) and sometimes the 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:
Your child might receive the following benefits. Your child's 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. Your child might receive the following benefits. Your child's doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

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 may occur.
- Bleeding may occur. If bleeding is excessive, you may need a transfusion.
- Reaction to the anesthetic may occur. The most common reactions

Risks of this Surgery:

- **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 child's condition may not improve.
- **Functional loss.** Your child may have problems with balance after surgery. Your child may have problems with strength, feeling, speech and language, memory, hearing or vision after surgery
- **Bleeding.** Bleeding in the brain is rare. This may need more surgery
- **Hydrocephalus**. The normal flow of spinal fluid around the brain may change. This may need more treatment or surgery
- **Increased pain.** Pain may get worse after this procedure. Your child may have a headache for up to a month or longer after surgery and sometimes for a longer period of time.
- **Infection.** Infection may occur in the wound, either near the surface or deep in the tissues. This could include

the bone. Your child could develop meningitis (inflammation of the tissues covering the brain and spinal cord) or a brain abscess (pus collected in an area of the brain). Your child may need antibiotics or more treatment.
- **Neurologic decline**. Your child 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.** Your child may develop seizures.
- **Spinal fluid leakage.** A spinal fluid leakage may cause a spinal headache. This could need more surgery.
- **Anaphylactic shock.** You may have a serious allergic reaction to the medicines used in the procedure. In rare cases, death may occur.

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:

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Alternative Treatments:
Other choices:
- Medicines may help with some symptoms such as headache.
- Observation with neurological exams and CAT scans or MRIs
- Do nothing. You can decide not to have the procedure for your child

If You Choose Not to Have this Treatment:
- You may choose to have alternative treatments listed above
- Your child’s neurological function may decrease. Herniation (when the brain swells more than the skull can hold) or death may occur.
- Your child may develop a syrinx or syringomyelia (a pocket of fluid in the spinal cord). This may lead to pain or loss of function

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

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 my child to have this procedure: **Suboccipital craniectomy with or without cervical laminectomy for Chiari Malformation.**
- 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/Parent 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:__________