BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Informed Consent: Shoulder Replacement Surgery

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

Reason and Purpose of this Procedure:

A **partial** or **total shoulder replacement** is an operation done to treat the pain and stiffness of the shoulder. The pain may be caused by arthritis or a fracture. A **reverse total shoulder replacement** is an operation to treat pain and problems caused by a rotator cuff tear that cannot be repaired, fracture of the shoulder, or arthritis.
The damaged surfaces of the shoulder are replaced with an implant that is made of metal and plastic. It may be attached to your bone with acrylic cement. The goal of the shoulder replacement is to:

- Reduce pain
- Improve use of the shoulder

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.

- Less pain
- Improved use of your shoulder during normal activities
- 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 may occur.
- Bleeding may occur. If there is a lot of bleeding, you may need a transfusion.
- Reaction to the anesthetic may occur. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you.

Risks of this Procedure:

- **Infections are rare, but serious when they occur**. Treating infections can require antibiotics, and sometimes more surgery. The new shoulder replacement may need to be removed to cure the infection.
- **The device can loosen or wear over time**. This can cause pain and you may need more surgery.
- **Dislocation of artificial joint may occur**. There is increased risk after surgery and during healing process which is why activity is restricted and shoulder immobilizer used. Additional surgery to stabilize the joint may be needed
- **Fracture around shoulder implant**. A fracture may occur during the surgery when the bone is prepared for the shoulder implants.
- **Damage to nerves and arteries can occur**. Nerve damage can cause numbness or weakness in the arms. Artery damage can cause a lot of bleeding and require repair.
- **Blood clots**. Blood clots may form in the legs, pelvis, or arm, with pain and swelling. These are called DVTs or deep vein thromboses. 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 shoulder.

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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 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:

- Do nothing. You may decide not to have the procedure.
- Pain medications
- Steroid injections
- Physical Therapy
- Exercise

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.

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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: ☐ Right ☐ Left **Shoulder Replacement Surgery** _____

  _____
- 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: _____