BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Informed Consent: Partial Hip Replacement Surgery

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

Reason and Purpose of this Procedure:

A partial hip replacement is an operation done to treat a certain type of hip fracture. The fractured (broken) ball of the hip is removed and replaced with a new metal ball. It may be attached to your bone with cement. The hip socket is not replaced. The goal of the partial hip replacement is to allow you to walk and return to activities.

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 ability to walk

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.** You may need antibiotics, and more surgery. The new hip part might need to be removed to cure the infection.
- **The device can loosen or wear over time.** This can become painful. You may need more surgery to treat the problem.
- **The device can come out of place.** This can be painful. You may need hospitalization to put the device back in place.
- **A difference in the length of your leg can occur.** This is usually minor. You may need a lift in your shoe if the difference is major.
- **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.
- **Blood clots.** Blood 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.
- **Continuing pain.** There may be some lasting pain or stiffness in the hip.
- **Decreased walking ability.** Sometimes people cannot walk the same way they did after a hip fracture. For example, if you used a cane before your injury, you may need to use a walker afterwards.
- **Other medical problems can worsen.** Sometimes a hip fracture can put a big shock on your system. Heart and lung problems can get worse, making it harder to recover from the surgery.

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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:

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 medicines.

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: **Partial Hip Replacement** _____

  _____
- 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: _____