



Patient Name: _____ Date of Birth: _____

Attending/supervising physician: _____

Resident physician (if applicable): _____ Type of supervision: ___Direct ___Indirect

This information is given to help you make an informed decision about treating a broken bone (fracture) or a dislocated joint. This is also called a closed **joint or fracture reduction**.

Reason and Purpose of Procedure:

A closed reduction of a fracture means fixing your broken bone without doing surgery. The doctor will move the bones into the right place so that the ends meet and they can heal. A closed reduction of a joint means moving a joint that is out of place (dislocated) back into place. You may have a splint, cast, or brace to keep the bone in place while the bone or joint heals. The doctor may give you medicine to relax you (sedation) or medicine to numb the area.

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.

- Putting the dislocated joint or broken bone into normal position. This will lessen the chance nerves or blood vessels will be injured.
- Reduced muscle spasms
- Improved function after the bone or joint heals
- Reduced pain

Risks of Procedure:

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.

Risks of this procedure:

- Possibility of causing a new break that may require more repair.
- The dislocation or break might move out of place after treatment. More treatment or surgery may be needed.
- Potential of injury to blood vessels that may require surgical intervention.
- Injury to nerves that may cause numbness and tingling, or problems moving.
- The break might not heal and surgery may be needed.
- Continued pain.

Affix Patient Label

Patient Name: _____ Date of Birth: _____

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:

Alternative Treatments:

- Open surgery to achieve an open reduction and internal fixation.
- Traction
- External fixation

If you choose not to have this treatment:

- You could lose the function in the area of the fracture/dislocation.
- Blood supply to the affected area could be diminished to the point of potential loss of limb.

If you decide not to have this procedure, there may be associated risks to this decision. Please discuss it with your doctor.

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.

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: **Joint/fracture reduction.**
- 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 the 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 surgery. If so, please obtain consent for blood/products.

Patient

Signature _____

Date _____ Time _____

Relationship Patient/Parent of Minor Closest relative (relationship) Guardian/POA Healthcare

Witness

Date

Time

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 (if applicable)

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: _____ (patient signature)

Validated/Witness: _____ Date: _____ Time: _____