First Hill
SURGERY CENTER

Parathyroidectomy Consent Form

Patient Name: ______________________ Date of Birth: _____

Guardian Name (if applicable): ______________________ Patient ID: _____

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

1 MY PROCEDURE

I hereby give my consent for Dr. ___________________________ to perform a **Parathyroidectomy** upon me. I understand the procedure is to be performed at the First Hill Surgery Center. This has been recommended to me by my physician in order to **diagnose and/or treat abnormal thyroid conditions or to remove parathyroid glands or parathyroid tumors.**

I understand that the procedure or treatment can be described as follows:
Parathyroidectomy: In an outpatient setting, an incision will be made just below the Adam's apple to locate the four parathyroids. Depending on the individual situation, up to three glands and a portion of the fourth may be removed. Thyroid surgery may require may include biopsy, complete removal of the thyroid (total thyroidectomy), removal of half of the thyroid (lobectomy), or removal of some thyroid tissue (partial thyroidectomy).

Typical recovery times include up to 7-10 days off from all usual activities.

This procedure requires general anesthesia which will be administered by a qualified anesthesiologist.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Reduction of excessive hormone production by the parathyroid glands, removal of cancerous tissue, increased ease of breathing and/or swallowing, controlled hormone production.

3 MY RISKS

*I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.*

These could include but may not be limited to the following:

- Bleeding, bleeding requiring a return trip to the operating room, postoperative infection, prolonged recovery, unaesthetic scar formation, temporary or permanent hoarseness, hypoparathyroidism, additional surgery, difficulty with airway obstructions, long-term or permanent calcium, Vitamin D supplementation, inability to localize the parathyroid adnoma, development of a second adnoma and/or parathyroid hyperplasia, and hungry bone syndrome.

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

4 **MY CONSENT**

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures**.

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required**.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests. Alternatives to this procedure may include, but are not limited to non-surgical options such as calcium therapy, observation by serial ultrasound, repeat fine needle aspirates & medication. These alternative forms of treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed **Parathyroidectomy** and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

Patient Signature: ________________________________ **Date:** ______ **Time:** ________

Patient is unable to consent because ______________________. I therefore consent for the patient.
Authorized Consenter's Signature: ______________________________ Date: _______ Time: ______
Printed Name: ______________________________ Relationship to Patient: ____________________

☐ Mark this box if telephone consent

Witness Name: ____
PRINT NAME
Witness Signature: ______________________________ **Date:** ________ **Time:** _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: ____
PRINT NAME

Physician Signature: ____________________________ **Date:** ______ **Time:** _____