First Hill
SURGERY CENTER

1101 Madison St., Suite 200 • Seattle, WA 98104-1306

Spine Surgery Consent Form

Patient's Name: _____ Date of birth: _____
Last, First, MI

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. _____ and associates to perform _____

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 treat _____

2. MY BENEFITS

Some potential benefits of this procedure include: relief of pain, restoration of neurological function, arrest of progression of neurological deficit, improvement of quality of life.

3. MY RISKS

I understand that there are **potential risks, complications and side effects** associated with any procedure. Although it is impossible to list all of them, I have been informed of the possible risks, complications and side effects of this procedure including: excessive bleeding resulting in transfusion, surgical site infection, partial or complete paralysis, spinal fluid leakage; vocal chord, esophagus, trachea or other major vessel injuries; injury to the lungs, heart, nerves and/or major vessels; change in skin temperature or swelling of the arms and/or legs; scar tissue of nerves and spinal chord following surgery can make nerve pain worse; bladder, bowel or sexual dysfunction; surgical implants can migrate and bone cement can extravasate into pleural, abdominal and/or retroperitoneal space and/or spinal canal; If a patient's own bone is used for bone graft, bone graft site pain, thigh pain and/or numbness can occur; injury to major vessels, and/or ureters, bowel and bladder can occur; Pseudo-arthrosis or non-union of intended fusion may occur and result in surgical implant failure; other complications not directly related to surgery including , but not limited to stroke, heart attack, blindness, blood clots, embolus to lungs, pneumonia, kidney failure and anesthetic death can occur; any of these complications may result in hospitalizations requiring additional medical and/or surgical treatment interventions. I also understand that surgery could make my conditions worse.

Although most of these risks, complications and side effects may occur only very rarely, they could occur and may not be predicted or prevented by the physician performing the procedure.

continued on next page.

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4. TISSUE DISPOSAL/PATHOLOGY

Any tissue or specimen may be disposed of in accordance with accustomed practice; or specimen sent to pathology for evaluation in agreement with my designated healthcare provider.

5. MY CONSENT

Although most procedures produce good outcomes, 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.**

If so, 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 treatment for my condition including no treatment** or other available non-surgical and surgical treatments.

I certify that I have read this consent or had it read to me and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed procedure(s) listed above 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 procedure(s) 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: _____