NEW JERSEY SPINE AND ORTHOPEDIC

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CONSENT TO SURGERY AND OTHER PROCEDURES

To the Patient or Person Legally Responsible for the Patient: You have the right as a patient to be informed about your condition, the recommended surgical, medical, or diagnostic procedures to be used and the risks and hazards so that you may make a decision as to whether or not to undergo the procedure. The disclosure is not meant to scare or alarm you. It is simply an effort to better inform you so that you may give or withhold your consent to the procedure any time prior to its performance.

Request and Consent for Treatment: I voluntarily request Dr. Katzman as my physician and such associates, students, technical assistants, and other health care providers as my doctor may deem necessary, to treat my condition which has been explained to me as:_____

_____

_____

Procedures to be performed: I understand the following surgical, medical, and/or diagnostic procedures are planned for me. _____

_____

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I understand that my physician may discover unforeseen conditions which may require additional for different procedures than those planned. If such a situation arises, I authorize my physician to perform such other procedures which are deemed appropriate in his/her professional judgement.

Use of Blood Products: I do / do not (circle one) consent to the use of blood and blood products as deemed necessary.

No Guarantees: I understand that the practice of medicine is not an exact science and certify that no guarantee or assistance has been made as to the results which may be obtained.

Benefits: The benefits of the procedures are possible decreased pain, possible decreased numbness.

Risks: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me.
I acknowledge that complications can occur with this or any procedure. I realize the risks associated with most surgical, medical, and diagnostic procedures include: infection, bleeding or hemorrhage, impotency, stomach, bowel, or bladder problems, pneumonia, sterility, blood clots in veins or lungs, blindness, deafness, need for transfusions, keloid and scar contractions, numbness, delayed healing, pain and discomfort, even death. I also realize that the following risks and hazards may occure in connection with this procedure: dural tear, headache, meningitis, nerver root injury, persistent numbness, back pain, blood loss, transfusion risks, infection, hematoma, nonunion if fusion performed with dislodging of graft, discoitis, hardware failure, esophogeal tear, hoarseness, sore throat, difficulty swallowing.

_____ (If checked, a more detailed description of the risks and benefits and alternatives associated with this procedures is attached to this form.)

(SEE BACK PAGE)

Alternatives: Alternatives to this procedure are: narcotics, morphine pump, spinal stimulator, wheelchair, epidural steroid injections, medication.

Anesthesia: I understand that anesthesia involves risks and hazards, but I request the use of anesthesia for the relief and protection from pain during the planned and additional procedures. I understand that certain complications may result from the use of any aneshesia, including respiratory problems, drug reactions, paralysis, brain damage, or even death. Other risks and hazards which may result from the use of general anesthesia range from minor discomfort to injury to vocal cords, teeth or eyes.

I understand that other risks and hazards resulting from spinal or epidural anesthesia include headache and chronic pain.

Disposal of Tissue: The hospital pathologist is hereby authorized to use his/her discretion in disposing of any member, organ, other tissue, foreign body, or hardware removed from my person during the above named procedure(s).

Photographs, Observers: I consent to the photographing and videotaping of the operations and procedures to be performed and to the presence of students or other observers in the operating room to observe the procedure. I am aware that only my surgeon may grant this permission on my consent. Any video/photographic doumentation, if used, would include appropriate portions of my body for medical, scientific, or educational purposes. My identity would not be revealed by descriptive texts accompanying the pictures.

I have been given the opportunity to ask questions about my conditions, alternative forms of anesthesia and treatment, risks of the planned procedures, risks of non-treatment, the procedures to be used and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. I voluntarily consent and authorize these procedures.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in and that I understand its contents.

Date/Time	Patient's Printed Name
Signature of Patient/Parent/Guardian/Conservator	If other than patient, indicate relationship to patient

WITNESS TO SIGNATURE ONLY

Date/Time	Name

We hereby certify that we have fully explained the risks and benefits of the procedure(s) listed above as well as alternative forms of treatment and answered fully all of the patient's questions.

	Scott Katzman, MD **Jeffrey Oppenheimer, MD** **Nader Hebela, MD**
Date/Time	Physician's Printed Name
Signature of Physician	