Spine Care Specialists
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# SURGICAL CONSENT
# FOR
# SPINAL INSTRUMENTATION

| ***Initial Below*** | |
|---|---|
| | I authorize DR. _____ (***and such assistants and associates as may be selected or designated by him***) to perform the following surgical procedure on me:<br>_____<br>_____<br>_____ |
| | |
| | I understand that every surgical procedure entails risks. The risks of this procedure include, but are not limited to, injury to the blood vessels and/or bleeding, injury to the nerves and/or muscles, injury to the bones and/or tendons or ligaments, and infection. |
| | |
| | I understand that this surgery may not completely resolve my complaints and that I may have residual symptoms after the surgery. I understand that I may even require additional surgery. |
| | |
| | I have received and reviewed the information and materials given to me regarding this surgical procedure and that all of my questions have been answered. I have been provided with the information I need to make a decision to undergo the recommended surgical procedure. |
| | |
| | I understand that there are other treatment options available and that I could continue to receive non-surgical treatments such as medication, physical therapy, and pain management. I also understand that I could undergo a different surgical procedure such as a fusion without instrumentation or with different instrumentation. I have discussed these options with my physician and I have voluntarily chosen to undergo this surgery. |
| | |
| | I understand that I can obtain the opinion of another physician before I undergo this procedure. If requested, my physician will provide me with the names or other doctors with whom I can discuss my condition and the proposed treatment. |
| | |
| | I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or the risks and consequences of the recommended procedure. |
| | |
| | I understand that any metallic fixation device may fail or break. If my fusion does not heal, the screws or rods may break or disengage. I understand that there is a possibility that the instrumentation may need to be removed and/or replaced at a later date. |
| | |

| ***Initial Below*** | |
|---|---|
| | I understand that my physician has completed a fellowship in spinal surgery. His elective practice is confined to evaluation and treatment of spinal disorders. By virtue of his special training and extensive practice experience, he has developed the knowledge and ability to safely use a pedicle fixation system. I understand that he believes that the use of spinal instrumentation significantly improves the chance that my fusion will heal. In spite of the risk inherent in tis use, my physician believes that the instrumentation comprises the implant which will provide me with the best opportunity for a safe and favorable outcome. |
| | |
| | I have reviewed the entire form ***(2 pages in total)*** and have initialed each paragraph to indicate my agreement with its contents. |

Date: _____ _____
Patient's Signature

Date: _____ _____
Physician's Signature

Date: _____ _____
Witness Signature