Cervical Spine General Consent Form for Operative and Invasive Procedures

DOCTOR(S): _____

has/have discussed my medical problem with me and has/have explained the following procedure(s) to be undertaken in lay terms completely understandable to me. I understand that my physician/surgeon may designate assistants, associates, residents, interns, technical assistants, and other health care providers as deemed necessary to assist him/her with the procedure(s) listed below.

Name of Procedure(s): _____

_____

_____

_____

_____

1. I have been fully informed and understand the potential benefits, risks and side effects of this care and also the likelihood of achieving goals related to this procedure. Any potential problems that might occur during recuperation have been explained to me. I have also been informed about reasonable alternatives and the risk of not receiving this procedure.
2. I have been fully informed of and understand the associate risks and the possibility of complications and the medically acceptable alternative(s) to the above-describe procedure(s). These risks or complications may include scarring; pain, infection, allergic reactions, lacerations or puncture of internal organ or vessels, bleeding requiring blood transfusion or return to surgery for repair, nerve damage, coma, heart, liver, kidney or lung complication and/or even in rare cases death. Other risks include: Bleeding, blood clot, infection, injury to trachea, esophagus, or carotid, seizure, stroke, difficulty breathing, temporary or permanent hoarseness, difficulty swallowing, spinal fluid leak, impotence, injury to the nerve or spinal cord, temporary or permanent numbness, tingling, pain, weakness, paralysis of the arms, legs,
3. I understand that my physician may discover other or different conditions which may require different procedures than those planned. If any unforeseen condition should arise during the course of the procedure, I do hereby authorize and request that the physician/surgeon and such associates, technical assistants, and other health care providers take whatever steps necessary to perform whatever procedure(s) they deem advisable, which may be in addition to or different from those now planned and have been discussed with me.
4. I have been made fully aware and acknowledge that the practice of medicine and surgery is not an exact science and that no guarantees or assurances have been made to me regarding expected outcomes.
5. I consent to the proposed procedures(s) by the above physician(s) and (their) associates. ☐ ☐

Use of Blood Products: I understand the risks and possible need for use of blood products and **I DO / DO NOT (Circle One)** consent to the administration or transfusion of blood or blood products to me during my procedure and/or its related treatment, whenever deemed necessary by those physicians attending to me, with no warranties made in connection with such blood or blood components.

Disposal of Tissue: I consent to the disposal by hospital authorities of any tissue, parts, organs, or extremities/limbs that may be removed in connection with my procedure(s). Tissues and/or organs, no longer needed for diagnostic purposes, may be used and/or photographed for research and educational purposes at HCA Florida JFK Hospital, and it's teaching facilities or for publication in an article related to medical research for the purpose of medical education.

Photographs/Observers: I consent to the taking of photographs, videotaping or other recordings in the course of this procedure for the purpose of advancing medical education as may be authorized by my physician(s) and to the admittance of qualified observers to opening/procedure room as determined by the hospital.

Medical Device: To comply with the provision of the *Safe Medical Act of 1990,* I consent to the release of my social security number for tracking purposes if a medical device is implanted.

Contrast Media: I understand the risks and consent to administration of contrast media (dye) during specific diagnostic procedures whenever deemed necessary by physicians attending to me. I assume all risks in connection with use of contrast media that include, but are not limited to, allergic reaction, nausea, thrombophlebitis, hives, or renal failure. Very rarely, an asthmatic attack, fall in blood pressure, or cardiac arrest can occur and medical treatment may be required to correct these conditions. In extremely rare conditions, a fatal reaction has occurred.

I have read and understand all of the above, have had an opportunity to ask questions concerning my planned procedure(s), and my questions have been answered to my satisfaction.

_____	_____	_____	_____
(SIGNATURE OF PATIENT)	(SIGNATURE OF WITNESS)	(DATE)	(TIME)

If patient is unable to consent or is a minor, complete the following:

Patient is unable to consent because: _____

_____

_____	_____	_____	_____
(SIGNATURE OF REPRESENTATIVE)	(RELATIONSHIP)	(DATE)	(TIME)

_____		_____	_____
(SIGNATURE OF WITNESS)		(DATE)	(TIME)

PHYSICIAN'S CERTIFICATION

NAME OF PHYSICIAN/SURGEON: _____

I hereby certify that the patient or one authorized to act on his/her behalf:

1. Has been fully informed by me or my physician associates, in lay terms understandable to the patient, the nature of the procedure(s), the medically acceptable alternative(s) to treatment, including refusal, and the consequences and risks to the patient inherent to or associated with the procedure(s); and
2. Has authorized the performance of the procedure(s).

_____	_____	_____
(PHYSICIAN'S SIGNATURE)	(DATE)	(TIME)

Patient Identification/Label