SPINE SURGERY OF IDAHO
A PIONEER AND LEADER IN EFFECTIVE TREATMENTS

STEPHEN MARANO, M.D. JAMES COOK PA-C

Patient Consent for Surgical Procedure, Post-Operative Care, and Medical Treatment

Patient Name: _____

I authorize Stephen R. Marano, M.D. to perform the following operation:

_____

1._____It has been explained to me that the following are some of the complications or unwanted side-effects that could or may occur: bleeding, infection, damage to adjacent tissues or organs, swelling, pain, suture reaction, delayed healing, scarring, anesthesia or medication reaction, recurrence of symptoms, the need for additional operations, and in rare instances, coma visual loss, hearing loss, stroke, bowel/bladder dysfunction, paralysis, or death. Additional complications or unwanted side-effects that could or may occur are:

_____

2._____The nature and purpose of the surgery, the risks of the operation and the possibility of complications have been explained to me.

3._____The non-surgical treatment options and their potential risks, complications, and benefits have been explained to me. I understand my options and that I have the right to seek another medical opinion about my medical condition.

4._____No guarantee or assurance has been given by anyone as to the results that may be obtained.

5._____I consent to the administration of anesthesia by an anesthesiologist or other qualified party (nurse anesthetist) who is under the direction of the anesthesiologist. I understand that the administration of any anesthetics involves risks and/or complications and these will be explained to me by the hospital anesthesia team prior to surgery.

6._____I am aware that I have an allergy or adverse reaction to the following medications:

_____

7._____I consent to the disposal of any removed tissue or body parts in accordance with hospital policy.

8._____For the purposes of advancing medical education, I consent to the admittance of observers to the operating area and to the use of photographic and/or video recording of part or all of the procedure.

9._____I understand that the explanation I have received is not exhaustive and that other, more remote risks and consequences may arise, and that I will be given a more detailed and complete explanation of any of the forgoing matters if I so desire.

10. _____This procedure ____**is** ____ **is NOT** an emergency where further delay may result in loss of life, coma, brain damage, and/or permanent neurologic deterioration.
11. _____I ____ **do**____ **do NOT** consent to the transfusion of blood and blood products as deemed necessary by my surgeon or the anesthesia team. The risks of, benefits of, and alternatives to receiving blood will be explained to me if I so desire. Possible adverse reactions include but are not limited to: chills, fever, itching, other mild allergic reactions (including breakdown of the red blood cells) and possible exposure to infectious diseases. These risks exist, despite careful testing of the blood and blood products. The blood may be donated by me for my own use and/or received from the hospital blood bank.

I have read and understand the information presented in this form, and my questions have been answered fully and to my satisfaction. I concur with the proposed treatment plan. Should questions arise between now and the time of the operation, I will contact Dr. Stephen R. Marano for further clarification. I have received a copy of this consent if requested.

Name _____Signature _____

Date/Time _____Relationship to patient _____
(If not signed by patient)

Witness _____Translator _____