

ANTERIOR CERVICAL DISCECTOMY

Anterior cervical discectomy is a procedure that is intended to relieve pain, numbness, balance disturbance and/or weakness that may be associated with cervical disc disease. Discs are small masses of rubbery tissue that act as natural shock absorbers between the individual bones of the spine. The procedure is performed on the upper spine to relieve pressure on the spinal cord or on the nerve roots. This pressure may be caused when a disc ruptures (herniates), causing the softer substance from the center of the disc to bulge through its tough, fibrous outer ring and press on the nerve or spinal cord. Additional nerve or spinal cord pressure may be caused by bone spurs, or rough edges of bone, that sometimes develop around degenerated discs.

Patient's
Initials

_____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me

_____ I understand that the procedure may fail to relieve the symptoms and disability from which I suffer.

_____ I understand and accept that the most likely material risks and complications of an anterior cervical discectomy have been discussed with me and may include but are not limited to:

- *bleeding*
- *infection*
- *difficulty swallowing*
- *spinal cord injury*
- *heart attack or other cardiac complication*
- *stroke*
- *blood clot/phlebitis*
- *nerve injury*
- *nerve root injury*
- *recurrence*
- *increased pain*
- *respiratory difficulties*
- *adverse reaction to anesthesia*
- *failure of the vertebrae to fuse*

_____ I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.

_____ I understand and accept the risks of blood transfusion(s) that are unlikely but may be necessary.

_____ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring but cannot control its ultimate appearance.

_____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.

_____ I have informed the physician of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

_____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made.

_____ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

Continued

_____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.

_____ The doctor has answered all my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, M.D./D.O., with associates or assistants of his or her choice, to perform a anterior cervical discectomy on

_____ at _____, on the
(patient name) (name of facility)

right at _____
Level

left at _____
Level

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician Signature/Date/Time

_____ copy given to patient
initial

_____ original placed in chart
initial