THE SPINE INSTITUTE, P.A.

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Diplomate American Board of Spinal Surgery
Diplomate American Board of Orthopaedic Surgery
Fellow – American College of Spinal Surgery

Patient________________________________ Date____________________________

Patient Consent to Spinal Surgery
Open Anterior Cervical Disc Fusion

I have been advised to carefully read and consider this special operative permit. I realize it is important that I understand this material. I also understand that if certain sections of this form are not clear to me, I have the opportunity to ask for clarification. I understand that Marc A. Cohen, MD, is an orthopedic surgeon in practice at 221 Madison Avenue, Morristown, NJ. Dr. Cohen is a specialist in spinal surgery.

I am fully aware of the condition of my spine and after careful consideration, have decided to undergo surgery to help my condition. I, herby, authorize Dr. Cohen to perform my surgery.

For my problem, Dr. Cohen has recommended an **Open Anterior Cervical Disectomy, Interbody Fusion, Cage Stabalization at level(s) ______________________.**

I hereby authorize Dr. Marc Cohen, M.D. and/or such assistants as may be selected by him to perform the surgical procedure(s) listed above.

I understand that this permit will discuss spinal surgery in a general way, including lumbar discectomy, lumbar decompression (or foraminotomy), anterior cervical discectomy and fusion, posterior cervical laminectomy (or foraminotomy) and or fusion, posterior lumbar fusion with instrumentation.

I have also had a detailed discussion and understanding of my spinal condition and those options with Dr. Cohen during my office consultation where he showed me models, neuro diagnostic testing of my problem. In addition, he showed me the model of the spinal implants that would be placed at the time of surgery.

I understand that my doctors will perform an operation on my spine, which may consist of evaluating the nerves, decompressing them, removing disc(s), possibly taking a bone graft (or using banked bone) and performing bone grafting. I understand that my doctor will be best able to evaluate the exact condition of my spine at the time of surgery. During the operation, he may vary the exact nature of the operation to treat my problem for the best outcome and smallest possible risk.

I consent to the performance of operation and procedure in addition to or different from those now contemplated and described herein that my doctor and his associates may deem necessary or advisable during the course of the presently authorized because of unforeseen conditions.

I understand that medical personnel may be present to observe surgery; I also understand that pictures or videotapes of my surgery or x-rays might be used for educational purposes. I give my consent to

these educational efforts and realize that they in no way affect my care. My identity will not be disclosed if my x-rays or pictures or videotapes are used at any time.

I understand that spinal care is not an exact science, and there are differences in opinion among doctors as to the best methods of treatment, and as to when or if they should be employed. I understand that this also is not known with absolute certainty which procedures are the best outcome for a given spinal problem.

I understand that this surgery is elective in nature, and that no potentially life-threatening condition would be left untreated if I decline at this time.

I understand that I am free to ask other opinions about the proposed surgery, and that my doctor encourages me to do this if I wish.

My doctor had discussed and fully informed me about following information in explaining the nature of my problem, the proposed operation, the possible complications of surgery, and the likelihood for a successful outcome:

A. The nature and purpose of the proposed procedure(s). I understand that in general, the surgery is to help relieve pain and to improve functions, but that these goals may not be attained.
B. The risks, possible complications and possible adverse effects of the proposed procedure(s) include the risk that the surgery may not accomplish the desired objectives. The major risks follow; I fully understand that other problems may occur.
    I. General problems (which my occur with any surgery)
        - Death
        - Deep venous thrombosis (blood clots), phlebitis, embolism
        - Infection
        - Pneumonia
        - Stroke
        - Anesthesia problems
        - Blood loss
        - Allergic reactions to medications or materials
        - Diseases transmitted by blood transfusion or other means
        - Retrograde ejaculation
        - Sexual dysfunction

    II. Problems related to spinal surgery (5%-20% of patients operated)
        - Unresolved symptoms
        - Pain, discomfort or other sensations which might not have been present preoperatively
        - Bone graft placed at surgery might not grow together, resulting in non-union of the fusion
        - Reoccurrence of symptoms later on in time

    III. Less common problems relates to surgery (1%-5% of patients)
        - Paralysis
        - Numbness

- Hoarseness (with anterior cervical procedures)
- Difficulty swallowing (with anterior cervical procedures)
- Spinal fluid leakage
- Headaches
- Worsening of symptoms
- Symptoms where there are none presently, such as the other arm or leg
- Loss of bowel or bladder control
- Arachnoiditis (scarring of the nerves in the dural sac)
- Graft site pain or numbness

C. The possible or likely consequences of the proposed procedure.
D. I also understand that the other problems might develop within my spine, which might require additional treatment or even another operation.
E. Reasonable alternative, treatment and their risks, consequences, and problem effectiveness have been discussed with me, including:
    - Doing nothing
    - Conservative therapy with drugs, and/or exercise and/or blocks
    - Decompression alone
    - Anterior disc procedure
    - Percutaneous disc procedures
    - Decompression with fusion
    - Decompression with instrumentation and fusion

In procedures requiring bone grafting, I understand that healing of bone graft into a bone fusion is largely a function of my body, and failure of the bone to incorporate is not necessarily related to the operative techniques. Furthermore, I understand that if the vertebrae in my spine do not grow together to form a fusion, reoperation may be necessary for me to experience improvement.

I have been informed that smoking adds to risks of surgery. Specifically, smoking can retard the healing of bone grafts leading to non-union. Dr. Cohen has informed me to quit smoking prior to surgery

I am aware that in addition to the risks specifically described above, there are risks that attend the performance of any surgical procedure. I am also aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment(s). It has been explained to me that significant improvement in spinal surgery occurs in about four out of five (80%) patients, and ranges from 50% to 90% for various procedures and clinical situations. I understand that an average of one patient out of five does not have significant improvement with this type of surgery.

I am aware that it is not possible to "cure" or totally correct the problem in my spine. I understand that the procedure(s) proposed will only possibly repair or reconstruct the problem areas in my spine.

I understand that there is likelihood that I will have some ongoing discomfort in my spine. My doctor has advised me that some patients still suffer from significant discomfort.
I understand that for these patients still experiencing significant discomfort, reevaluation and possibly re-operation may be recommended to try to help relieve suffering. About one patient in seven (15% of patients) may need re-operation. I understand, in general, I must allow sufficient time for healing and that my doctor will advise me of the best time for these evaluations, if necessary.

Patients with spine problems occasionally require narcotic medications to suppress their pain. These narcotic medications (Percocet, Codeine, Demerol, Valium, etc.) are addicting. While my doctor will prescribe medications to suppress the pain associated with surgery, after three months post operatively, they will limit the use of these medications. If he should feel that I have developed an addiction to them he will refer me to a specialist and I understand that he does not deal with chronic addictive pain patients.

I understand that my doctor is experienced in spinal surgery. However, I understand that while I may go to another surgeon(s) if I desire, I have chosen Dr. Cohen. I agree to hold Dr. Cohen harmless if I do not have a successful outcome from surgery, or if I experience side effects of complications of surgery. I understand that even if the surgery is well planned and performed, some patients will have problems continued pain, or complications after the operation.

Spinal Instrumentation

I understand that spinal implants may be used in my surgery to improve "fixation". Attempts to use spinal implants may be aborted for technical reasons that may include problems of bone strength or bone anatomy. Additional risks of implants include breakage and loosening of the components due to fatigue failure. Also, nerve root and spinal cords impingement resulting from malposition screws of bone fragments dislodged by screws can occur.

I impose no specific limitation or prohibitions regarding treatment other than those following: (or write NONE)

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I have had ample opportunity to discuss my condition and treatment and surgery with my doctor, and his associates. All of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base my decision regarding the proposed operation, and to sign this permit for the operation.

I am under <u>no</u> pressure or duress from anyone to proceed with surgery, and my doctor will continue to treat me for my spine problem even if I do not have surgery.

I have accepted a copy of this consent to review at any time prior to surgery.

I fully understand that the proposed spinal surgery is elective, and that I can continue to treat my problem without surgery if I do desire.

Patient Signature: __________________________ Date: ____________________

Witness Signature: __________________________ Date: ____________________

Physician Signature: __________________________ Date: ____________________