

DISCLOSURE AND CONSENT
MEDICAL AND SURGICAL PROCEDURES

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and to any recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for the proposed procedure.

____ I (we) voluntarily request Dr. Morrison, as my physician, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition which has been explained to me by my physician as:

_____ and
hereby release my physicians and other participating health care providers from any and all liability for any adverse effects that may result from these procedures.

____ I (we) understand that the following surgical, medical and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize the procedure of spinal cord stimulator implantation to reduce pain. Alternatives include: live with the pain, stronger medication, brain stimulator.

____ I (we) understand that my physician may discover other or different conditions which requires additional or different procedures than those planned. I (we) authorize my physician and any such associates, technical assistants and other health care providers to perform such other procedures which are advisable in the professional judgments.

____ I (we) do/do not consent to the use of blood and blood products as deemed necessary. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realized that the following risks and hazards may occur in connection with this particular procedure: 2-10% risk of infection resulting in removal of all parts; 10-30% risk of future malfunction of internal parts, 4% risk or a new increased pain; ½% risk of death, permanent or temporary paralysis or loss of feeling and/or coordination of bowel, bladder, and/or sexual organs; failure of stimulator to relieve pain; undesirable changes in stimulation may occur in time; radicular chest wall stimulation; leakage; persistent pain at the electrode or receiver site; seroma at receiver site; receiver migration; allergic or rejection response to implanted materials.

____ I (we) have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this Informed Consent.

____ I (we) certify this form has been fully explained to me (us) and that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in and that I (we) understand its contents and that a copy of this form has been made available to me (us).

Date: _____ Time: _____ am/pm

Signature of patient or other legally responsible person

Witness: _____