Patient Name: _____ I authorize Dr.(s) Sanjay Jatana, M.D.

To do (medical term): _____

(Description in lay terms): _____

_____

I understand the reason(s) for the procedure is: to stabilize the spine and alleviate pain

My doctor has discussed the nature of and reason(s) for the treatment or procedure with me. He or she has discussed the usual risks, expected benefits, and possible discomforts, including any problems related to recuperation.

RISKS - I know about the following problems which may occur with respect to my treatment or procedure.

1. **Surgical or other invasive procedure:** The more common risks and hazards include: infection, bleeding which may require blood transfusion, nerve injury, additional surgery, blood clots, heart attack, allergic reactions, and pneumonia. These risks can be serious, extending hospital stay and possibly fatal. **The significant risks, complications or side effects of my treatment or procedure are:** _____

   _____

2. **Drugs and Anesthesia:** The administration of drugs and anesthesia, even local anesthesia, also involves risks, the most significant of which is a risk of reaction which could cause death.

ADDITIONAL PROCEDURES – I understand that during the procedure problems may arise. These problems may require a procedure different from that listed above. If another procedure is needed, I authorize my doctor or his or her designee to do whatever procedure is considered to be in my best interest.

ALTERNATIVES – The doctor has discussed other methods of treatment, and the risks, benefits and possible side effects of these alternatives, including the risks and expected results of not having this or any other treatment or procedure. The treatment or procedure indicated at the top of this form is the one I have chosen.

TRANSFUSION OF BLOOD OR BLOOD PRODUCTS – The doctor has informed me that it may be necessary to receive blood or blood products in connection with my care. The potential risks, benefits, and alternatives of blood transfusion, including what could happen if transfusion is refused, have been explained and I understand them. I understand that transfusions can be done with blood donated by others, from someone I choose, or, if I am the transfusion recipient, with my own blood. I understand risks of transfusion exist even though blood is screened for Hepatitis, AIDS virus and other diseases. I consent to transfusion of blood or blood products.

Please initial: _____ I do not consent to transfusion of blood or blood products.

NO GUARANTEE – I have been informed about the likelihood of success of this treatment or procedure. I understand that the treatment or procedure may not cure my condition or illness and that no guarantee of a successful outcome has been or can be made.

VISITORS and PHOTOGRAPHY - I understand that students or medical sales representatives may be present to observe my treatment or procedure. I also understand that my treatment or procedure may be photographed or videotaped for purposes of documentation.

OTHER PRACTITIONERS – I understand that other health care practitioners may participate in performing this treatment or procedure. The names of others who may perform significant portions of this treatment or procedure as described above.

Please initial: _____ I have a Do Not Resuscitate Order (DNR) and/or Cardiopulmonary Resuscitation (CPR) Directive and **wish to suspend it/them** during this operation or procedure(s) peri-operative period (the peri-operative period is the time from which the anesthesiologist or the physician performing the surgery assumes the care of the patient, through the procedure, and until the patient's care is transferred back to the primary care physician. This may include "recovery time" if indicated by the procedure: i.e., pre-op, intra-op, and post-op).

ANY CHANGES OR STRIKE-OUTS MUST BE INITIALED BY PATIENT (OR SUBSTITUTE DECISION-MAKER) AND PRACTITIONER

Patient Information/Label

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM

PATIENT'S CONSENT: I have been allowed to ask questions about this treatment or procedure. I have read this consent form and/or it has been explained to me. I understand the risks and give my consent to this treatment or procedure.

Patient Signature/ Surrogate (indicate relationship)	Date	Time

PHYSICIAN'S STATEMENT: The patient or his or her Surrogate Decision-maker and I have discussed the procedure or treatment. The discussion included the risks, complications and alternatives of both the procedure and blood products that may need to be administered. To the best of my knowledge, the patient or decision-maker understood the discussion, all questions have been answered, and the patient or decision-maker consents to the procedure and transfusion, if applicable.

Physician's Signature	Date	Time

MODERATE SEDATION/ ANESTHESIA

Type of medication _____

I have been provided an explanation of the available sedation/analgesia options and associated procedures with their various benefits and risks. It has further been explained to me that:

- It is not uncommon for a patient to experience one or more of the following short-term side effects from sedation/analgesia: Nausea, vomiting, slurred speech, amnesia, itching, agitation and confusion.
- With any sedation/analgesia procedure there is always the possibility of unexpected side effects or complications such as allergic reaction, increase or decrease in blood pressure, increase or decrease in heart rate, decreased respirations, respiratory arrest, and cardiac arrest.

PATIENT'S CONSENT: I have read, or it has been explained to me, and fully understand this Informed Consent form, and understand I should not sign this form if all my questions have not been explained to my satisfaction or if I do not understand any of the terms or words contained in this Informed Consent form.

Patient Signature/ Surrogate (indicate relationship)	Date	Time

PHYSICIAN STATEMENT: The patient or his or her substitute decision-maker and I have discussed the anesthesia to be used. The discussion included the risks, complications and alternatives to the analgesic. To the best of my knowledge, the patient or decision-maker understood the discussion, all questions have been answered, and the patient or decision-maker consents to the analgesia.

Physician's Signature	Date	Time

ANY CHANGES OR STRIKE-OUTS MUST BE INITIALED BY PATIENT (OR SUBSTITUTE DECISION-MAKER) AND PRACTITIONER

Patient Information/Label