

**Taylor Spine Consent
Patient Information on Spinal Surgery
BRETT A. TAYLOR, M.D.**

Patient's Name: _____

Diagnosis: _____

Nature of Treatment Proposed: _____

(Performed by Dr. Taylor and Dr. Taylor's Spine Team)

Layman's Description: _____

Other treatment options and their risks: _____

Dr. Taylor believes every patient has the right to determine what should be done with his or her body. This information is provided to help you understand the risks of your upcoming operation. It may also help you uncover areas you do not understand. This is an educational tool to be used in addition to your discussions with Dr. Taylor and his staff.

“This is an informed exercise of choice”

Please initial after reading and agreeing to each numbered item if Dr. Taylor and his staff have answered your questions and concerns. Please conclude the consent by signing your name with a witness present.

1. _____ My surgeon has informed me that the decision to have this surgery is mine and I am proceeding with this surgery at my request. **I am consenting that I choose to have surgery, and I feel I have exhausted non-surgical treatments.**

2. _____ Reasonable alternative treatments and their risks, outcomes, and probable benefits have been discussed with me, including doing nothing, conservative therapy with drugs and/or exercise and/or nerve blocks or injections.

3. _____ Medical personnel may be present to observe surgery. Pictures or videotapes of your surgery or x-rays may be used for educational purposes. These educational efforts in no way affect your care. Your identity will not be disclosed if your x-rays, pictures or videotapes are used at any time.

4. _____ There is not one right answer regarding treatment for spinal problems. Dr. Taylor has provided me with his suggested management of my problem. I am aware that I am free to seek other opinions about the proposed surgery; **and Dr. Taylor and his team encourage me to do this if I wish.**

5. _____ I understand that after surgery I may have continued problems or worsening of symptoms. I understand that less common problems which may occur as a result of surgery include: paralysis, numbness, change or loss of voice, difficulty swallowing, spinal fluid leakage, loss of bowel or bladder control, scarring of the nerves in the dural sac (arachnoiditis), loss of sexual function, and infertility. Other problems might develop within the spine, which may require additional treatment or even another operation. I understand that it is **not possible to cure or totally correct your spinal problem.**

6. _____ More serious risks of surgery include: blindness, blood clot, pulmonary embolism, phlebitis, infection, pneumonia, stroke, anesthesia complications, blood loss, allergic reactions to medication or materials (implants), and diseases transmitted by blood transfusions or other means.

7. _____ I consent to the spinal surgery despite the risks mentioned here and any other risks associated with surgery.

8. _____ Patients that have any of the following may be at risk of surgical wound infections: **diabetes, cigarette smoking and the use of nicotine products, obesity (>20% ideal body weight)**, systemic steroid use, a tooth abscess, urinary tract infection, older than age 65, nutritional status, and transfusion of certain blood products.

9. _____ I understand and **agree** to refrain from smoking, using tobacco products, or nicotine patches prior to my surgery and for a period of at least 6 months following my surgery.

a. Patient's Signature

10. _____ Patients who undergo surgery for herniated discs have a 25% risk of recurrent disc herniation at the same site.

11. _____ Usage of narcotics prior to surgery will increase your risk of a pain after your procedure. Dr. Taylor will prescribe pain medication after your operation for 8 to 10 weeks. Additional narcotic pain management beyond 3 months will require a consultation with a pain specialist.

12. _____ I understand that I must obtain HIBICLENS Soap and that I am to scrub my back/neck as instructed on the directions. I understand that this may help to reduce my risk of infection.

13. _____ I understand that I may require one or more blood transfusions during or after my spine surgery. My questions/concerns about blood donation/transfusion have been answered by Dr. Taylor or his staff.

14. _____ I understand that Dr. Taylor may ask that I see a family doctor or an anesthesiologist to obtain medical clearance before my surgery. I also understand that this medical clearance is not a guarantee against a complication or medical problem during my stay.

15. _____ I understand that once my pain is controlled on oral pain medication I will be able to go home. If I am unable to go home in 1 to 2 days due to weakness or inability to properly care for myself at home, I may be transferred to either a rehabilitation unit or a skilled nursing facility until I can function and care for myself at home.

16. _____ I understand that risks/complications are possible with spine surgery and these risks/complications listed on this, Taylor Spine Consent form, have been explained to my satisfaction.

Business hours are Monday-Friday 8:00 a.m. – 4:30 p.m., except holidays.
IMPORTANT: Refills of medications need to be done during business hours
NO pain medications will be given over the phone, after hours, or on weekends.

b. **Patient's Signature** _____

c. **Witness' Signature** _____

The above information is provided to help you understand the complications associated with spine surgery and to highlight areas where you feel you need additional information. This information is provided to educate you on the risks of surgery that can result in injury. As well you should know about any risk that might effect your decision to undergo surgery.

Patient's Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____
(Discussed procedure with patient)

Doctor's Signature: _____ Date: _____
(Discussed procedure with patient)

Lumbar Decompression Consent

In Dr. Taylor’s opinion, patients should only consider surgery for their lumbar disc after they have exhausted a trial of nonoperative treatment and they feel that they cannot cope with their symptoms of leg pain. If an individual cannot tolerate the uncertainty of a variable course of symptoms with nonoperative treatment, they might also consider surgery. This is often the case when leg pain or sciatic pain prevents a person from working, caring for themselves, caring for their families, then surgery is a reasonable option.

If you feel that your symptoms are intolerable and/or you do not want to pursue continued nonoperative treatment, then surgical treatment is a reasonable option.

Dr. Taylor’s comments:

Dr. Taylor Disclosure

Please be aware that Dr. Taylor and his partners, order, direct, and refer patients for treatment, testing, therapy, and/or rehabilitation at facilities in which he has a financial document. interest. These financial interests include partial ownership in facilities which perform imaging tests, provide DME services, and surgical centers.

Facilities: CT Partners, Imaging Partners of Missouri , & St. Louis Spine and Orthopedic Surgery Center.

You as a patient or employer of a patient have the right to refuse care at these facilities.

To all insurers, please notify any repricer you choose of Dr. Taylor’s Disclosure provided in this

Pain Management

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

Dr. _____ is prescribing a controlled substance/medications to me for the diagnosis of _____

This decision was made because other treatments have not been effective for my diagnosis. I understand this and any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit. Failure of pain symptoms to diminish in response to my prescriptions within reasonable doses will cause by doctor to choose another form of treatment.

Initials _____

I will only obtain prescriptions for pain medications from the doctor signing below, and will only fill my pain medicine prescriptions at this pharmacy:

Ph. No.: _____

I have told the prescribing doctor about all other medicines and treatments I am receiving and will continue to keep the prescribing doctor informed of any changes made. I am aware any medication is unlikely to provided complete pain relief. I have been informed f the potential risks and benefits of treatments not involving these medications. I will obtain approval from my primary care physician prior to filling my prescriptions.

Initials _____

I am aware that the use of such medicine has certain risks associated with it such as sleepiness or constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, and addiction. I am aware of these medications may impair my ability to drive a vehicle, operate heavy equipment, to be safe in a hazardous work environment, or care for another person.

Initials _____

I am aware that certain other medications such as nalbuphine (Nubain), pentazocine (Talwin), buprenophine (Buprenex), and butorphanol (Stadol), may interfere with my prescriptions, will not take any of these medicines, and will inform all my other doctors of my prescriptions and that I cannot take any of the medicines listed above.

I am aware that addiction is defined in part as the use of a medicine even if it causes harm of feeling the need to use the medicine even if not in pain. I am aware that the chance of becoming addicted to my pain medicine is very low, has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

Initials _____

Because these drugs have potential for abuse or diversion, strict accountability is necessary. I will protect these medications from damage, loss or theft and will not be prescribed refills earlier than the refill due date in any case. Any sale or intentional distribution of these prescriptions will result in termination of care and further prescriptions by the prescribing physician and this practice group. Blood and/or urine tests may be done at anytime to evaluate for non-prescribed substances, and/or adverse responses to these prescriptions.

Initials _____

If the responsible legal authorities have questions concerning your treatment, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

Initials _____

I understand that physical dependence is a normal result of using opioid medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. I am aware that opioid withdrawal may include many different symptoms of illness, and is uncomfortable but not life threatening.

Initials _____

___ (Males Only) I am aware that chronic opioid use has been associated with low testosterone in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

___ (Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid

Initials _____

Renewals are contingent on keeping scheduled appointments, and calls for prescriptions and/or refills are only received between the hours of 8:30 am and 4:00 pm, Monday through Friday

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my symptoms with one or more controlled substances, and agree to all terms of the treatment agreements detailed above.

Patient Name (Printed): _____ DOB: _____
Patient Signature: _____ DOB: _____
Physician Signature: _____ Date: _____
Physician Name (Printed): _____

If you are taking narcotic pain medication before surgery, you are at greater risk of pain management problems after surgery. As well, Dr. Taylor, will provide 6—8 weeks of pain medication after your surgery. If you need additional narcotics after 2 months, we will refer you to a pain specialist or refer you back to the physicians who originally prescribed your narcotic pain prescription.

Please list below any narcotic pain medication that you are currently taking and the name of the doctor who prescribed it to you.

Name of Pain Medication:

Prescribing Doctor's Name:

Dr. Taylor believes your present narcotic requirements are significant. We will need your pain management specialist to prescribe your postoperative narcotic medications after you are discharged from the hospital.

Patient's Signature: _____ DOB: _____

Patient's Name (Please Print) _____

Date: _____

Complex Elective Case

□ **If applicable**

Dr. Taylor feels you are at an increased risk for a poor outcome or a major complication. You are requesting an elective surgical procedure because you cannot live with your present symptoms and feel you have failed all non-surgical treatment therapies. Dr. Taylor has encouraged you to exhaust non-surgical management. However, you are requesting surgery instead of non-surgical care.

Dr. Taylor encourages patients to understand fully the risks of surgery before proceeding with any type of surgical intervention. Below you will find a brief list of some of the many complications which can occur with spine surgery. Please review these complications and discuss with Dr. Taylor further any questions or concerns you have regarding your particular case.

The risks of surgery include:

- Harmful reactions to anesthesia
- Lung problems including inflammation, infection or collapse of the lung, blood clots in the lung
- Infections of the wound or the skin around the wound
- The wound may not heal and open
- The tissues around the wound may die
- There may be swelling
- Blood clots can form in the legs. These clots can travel to the lung or brain
- Inflammation of a vein
- Changes in heart rhythm, including heart attack and death
- Strokes
- Complications of pregnancy
- Seizures, convulsions
- Loss of memory, confusion
- Hallucinations
- Changes in mental ability

Patient Name: _____ DOB: _____
Patient Signature: _____ Date: _____
Staff Signature: _____ Date: _____
Physician Signature: _____ Date: _____

Dr. Taylor requests that you review, in its entirety, the Educational Module. Please check and sign the areas below signifying completion.

____ The patient has reviewed The Taylor Spine Team Educational Module

Patient Signature: _____ Date: _____
Staff Signature: _____ Date: _____

