PATIENT CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE
ACKNOWLEDGMENT OF RECEIPT OF MEDICAL INFORMATION

INFORMATION ABOUT THIS DOCUMENT
READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: You have been told that you should consider medical treatment/surgery. Louisiana law requires us to tell you (1) the nature of your condition, (2) the general nature of the medial treatment/surgery, (3) the risks of the proposed treatment/surgery as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor, (4) reasonable therapeutic alternatives and material risks associated with such alternatives, and (5) risks of no treatment.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make a decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible: Please read the form carefully. Ask about anything you do not understand, and we will be pleased to explain.

1. Patient name: _____

2. Patient Condition: Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in item number 3 is indicated and recommended:

_____

_____

_____

3. Treatment/Procedure:

(a) Description, nature of the treatment/procedure: _____

_____

_____

(b) Purpose: Decrease pain and improve function.

_____

_____

4. Material Risks of treatment /procedure:

(a) All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether or have or forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below.

(b) Orthopaedic Surgery on Extremities: A surgical procedure upon, or even a closed manipulation of an extremity, entails risk to a greater or lesser degree, to all major systems of that limb, and can result in varying degrees of weakness, deformity, paralysis, pain, numbness, limitation of motion of the joints, and amputation. Blood transfusion may be required. Furthermore, the goals of the procedure may not be obtained, and other therapy may be found necessary.

(c) Risks and Complications of General Anesthesia:

A. Allergic, abnormal or hypersensitivity reaction to drugs or equipment, which may be fatal.

B. Aspiration (inhalation) into the bronchi (airway) or lungs of stomach contents, stomach acids and foreign objects.
C. Laryngeal and/or vocal cord trauma or edema (injury to or swelling of the vocal cords).
D. Heart attack or other heart problems.
E. Death.
F. Stroke or brain damage.
G. Shock.

(d) Risks and complications of Regional or Local Anesthesia:
A. Permanent nerve injury with resulting pain, numbness and weakness in the arm.
B. Arterial and/or venous thrombosis with vascular insufficiency to the arm resulting in permanent swelling and pain in the arm and/or hand.
C. Loss of the arm and/or hand.
D. All risks outlined in the risks and complications of General Anesthesia in section 4(c).

(e) Material Risks Identified by Physician: **Infection, bleeding, blood clots, mechanical failure, loosening or wearing out of prosthesis, dislocation, numbness around incision site, breaks or fractures in bones of involved extremity, wound or skin breakdown, leg length discrepancy.**

5. (a) Reasonable therapeutic alternatives and risks associated therewith:
1. Other medicines, injections and physical therapy.
2. Continued pain , loss of motion and function.

(b) Risks of no treatment: **Lack of treatment may result in continued symptoms (numbness, pain and weakness) and/or possible permanent injury with resulting irreversible loss of its function.**

6. ACKNOWLEDGEMENT AUTHORIZATION AND CONSENT

(a) No Guarantees: All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedures or as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either express or implied, as to the success or other results of the medical treatment or surgical procedure.

(b) Additional Information: Nothing has been said to me, no information, has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

(c) Particular Concern: I have had an opportunity to disclose to and discuss with the physician providing such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

(d) Questions: I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.

(e) Authorized Physician: The physician authorized to administer or perform the medical treatment, surgical procedures or other therapy described in Item 3 is: **Niels J. Linschoten**
and such others as he may designate.

(f) Physician Certification: I hereby certify that I have provided and explained the information set forth herein including any attachment, and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

CONSENT

Consent: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in item 3 of this Consent Form, including any additional procedures or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document, including any attachment, and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in item 3 of this consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

_____
Signature of Person Authorized to Consent

_____
Date and Time

_____
Signature of Physician

If consent is signed by someone other than the patient, state the reason and relationship_____