ADVANCED SURGERY CENTER OF METAIRIE, LLC

GENERAL SURGERY CONSENT FORM

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: You have been told that you should consider medical treatment/surgery. The Louisiana Medical Disclosure Panel Law requires us to tell you (**1**) the nature of your condition, (**2**) the general nature of the procedure/treatment/surgery, (**3**) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel, and (**4**) reasonable therapeutic alternatives and risks associated with such alternatives.

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 the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the Louisiana State Law of Informed Consent, you are being asked to sing 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 it.

1. Patient Name:_____

2. Treatment/Procedure: Left shoulder Yes No
Right shoulder Yes No

(a) Description, nature of the treatment or procedure:
Arthroscopic versus open rotator cuff repair, possible subacromial decompression, and other indicated procedures. This procedure is the surgical scraping of the in the top of the shoulder, and suturing of the tendon if it is torn. This is done through a big cut or through multiple little cuts.

(b) Purpose:
The pain should gradually improve making it possible to take up activities, which could not have been done prior to surgery because of pain and weakness in the shoulder joint.

3. Patient Condition:

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

Rotator Cuff Tear: The rotator cuff comprises muscles and tendons that surround the top of the upper arm bone (humerus) and hold it in the shoulder joint. A tear may result suddenly from a single traumatic event or develop gradually because of repetitive overhead activities. Rotator cuff tears may be partial- or full- thickness. Partial-thickness tears do not completely rupture the tendon and may respond well to non-operative treatments. Those that do not respond well or that develop into full-thickness tears may require surgery. Many full-thickness tears require surgery to correct.There are several surgical options to treat rotator cuff tears, depending on the size, depth, and location of the tear.

4. Material Risks of treatment procedure:

(a) The material risks associated with the medical treatment, surgical procedure, or other therapy described in item number 2 of this Consent Form, as required by the Louisiana Medical Disclosure Panel Law, are:

☒ See attachment for risks identified by the Louisiana Medical Disclosure Panel

☐ Not yet determined; risks as determined by your doctor are:

(b) Additional risks (if any) particular to the patient because of a complicating medical condition are:
Infection, blood clot in legs, pelvis, or lungs, neurologic injury, vascular injury, bleeding, heart attack, stroke, death, incomplete pain relief, joint stiffness, weakness, post-operative swelling, tendon non-healing or partial healing, failure of implants or sutures, chondrolysis (or death of cartilage cells), scarring, abnormal pain response to surgery with worsening pain and disability

(c) Risks generally associated with any surgical treatment/procedure, including anesthesia are: death, brain damage, disfiguring scars, paralysis, the loss of or loss of function of body organs, the loss of or loss of function of any arm or leg, infection, bleeding, and pain.

5. Therapeutic alternatives and risks associated therewith:

Reasonable therapeutic alternatives and the risks associated with such alternatives are:
The alternatives to this procedure include the following: rest, nonsteroidal anti-inflammatory medications, strengthening and stretching exercises, as part of a physical therapy program, corticosteroid injections, ultrasound, and alteration of your lifestyle.

6. (a) No Guarantees: All information given to me and, in particular all estimates made as to the likelihood of occurrences 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 guarantees, 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 Concerns: 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 (or physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in item 2 is:

Michael W. Hartman, MD_____

□ Surgical Assistant:_____

(check, if applicable)

Role: □Opening/Closing □Harvesting grafts □ Dissecting tissue □ Removing tissue □Implanting devices □ Altering tissues □Other_____

(f) Physician Certification: I hereby certify that I have provided and explained the information set forth herein 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.

_____ _____

Signature of Physician Date/Time

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 2 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 and all applicable 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 by me in writing.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in item 2 of this consent form, including risks or alternatives, and acknowledge that my questions have been answered to my satisfaction.

_____ _____

Signature of Patient Date/Time Signature of Patient Representative Date/Time

_____ _____

Signature of Witness Date/Time Print Representative's Name

_____

Relationship to Patient