I, _____ have been asked to carefully read
(Name of patient or substitute decision-maker)
all the information contained in this consent form and to consent to the procedure described below on behalf of _____. I have been told that I should ask
(Name of patient)
questions about anything that I do not understand. (If the decision-maker signing this form is not the patient, references to "I," "my" or "me" should be read as if referring to "the patient," when applicable).

I understand that the information about the procedure(s) described in this consent form, in addition to discussions with my physicians and any other written materials they may provide, is intended to help me make an informed decision whether to voluntarily undergo the procedure(s).

I understand that after being examined, treated, and having my radiological studies reviewed, I have been diagnosed as having probable bulging or herniated disc(s) in the lumbar or thoracic posterior portion of my spine at the following level(s) _____. Discs are shock-absorbing cushion between the vertebrae of the
(level(s) of suspected herniation)
spinal column. My symptoms are probably caused by disc material pressing on a nerve or nerves. The most common symptoms include pain, numbness and weakness.

I acknowledge that my physician(s) has/have recommended that I undergo a microdiscectomy (the "recommended procedure"). A microdiscectomy is the surgical removal of the disc material that is causing my symptoms. I understand that other material may also have to be removed to reduce the likelihood that my symptoms could recur. It is my desire to have the recommended procedure to try to eliminate some or all of my symptoms.

The side/site/location is_____.

Surgery: I will be put to sleep under general anesthesia. (The type of anesthesia and the risks of anesthesia will be explained to me by a representative of the Anesthesia Department.) I will then be positioned on the operating room table and my low back area will be cleaned and covered. A cut will be made, and an x-ray will be taken to show the surgeon(s) where the herniated disc material is located. Under magnification, the surgeon(s) will then remove as much disc and other material(s) as they reasonably believe should be removed in order to relieve my symptoms. In 1-7% of the population a transitional or extra vertebra exists between the lumbar and sacral area. If a transitional vertebra exists, the chance of surgery at an additional level may be increased.

I understand and consent to the surgeon(s) removing material at the level(s) of the spine identified above as well as at other level(s) that they believe in their judgment should be removed in order to relieve my symptoms or improve my health or well-being. The wound will then be closed. The surgery should take approximately 1 to 2 hours.

Post-Surgical Care and Recovery. After the surgery, I will be given pain medications. I may need to take other drugs such as muscle relaxants and antibiotics, depending on my condition. I understand that it is important for my physician(s) to know all drugs that I am currently taking in order to avoid any unwanted and harmful drug interactions. I agree that prior to the surgery I will inform my physicians about all drugs, medications, herbs or supplements I am taking.

It is anticipated that I will be discharged within 23 hours of my surgery. In most cases, patients are discharged the morning following the surgery.

However, my physician(s) will determine when I can be discharged from the hospital. I understand that I may have significant post-operative restrictions and limitations that have been thoroughly discussed with me.

Risks of Surgery: I understand that there are inherent risks in the performance of the recommended procedure. These include:

1. Post-operative pain. In most cases the pain diminishes, and patients end up with less pain after the surgery. Most patients obtain good to excellent pain relief with this surgery. However, there is the risk that the pain could remain the same after surgery or increase (<10%)
2. Symptomatic scar tissue at site(s) of incision(s). (10%)
3. Re-herniation of the disc. This occurs in approximately 5% of the patients who undergo disc surgery. Over time, one or more operations may be necessary if further herniation occurs.
4. Muscle weakness. In most cases, any preoperative muscle weakness and/or numbness will diminish and end up being less than before surgery. Full resolution may take weeks or months. However, there is the risk that the muscle weakness, numbness or other deficit could remain the same after surgery or increase or new muscle weakness or numbness could develop. (5%)
5. Damage to nerves or spinal cord at or near the site of the surgery that can cause neurological dysfunction, such as weakness, numbness or loss of use of arms and/or lower extremities, decrease or loss of bowel or bladder control and sexual dysfunction. (<3%)
6. Tears in the dura (covering of the spine) resulting in spinal fluid leak. Spinal fluid leak can cause headaches and spinal fluid infection (meningitis). In rare cases, surgery may be required to repair the leak. (<5%).
7. Infection at the site of the surgical incision(s); in the disc space between the vertebrae; in the blood; in the bladder; in the spinal fluid or other portions of the body. (<3%)
8. Blood clots (thromboemboli) can form in different parts of the body, most often in the legs. These clots can break free and move through the heart to the lungs. In the lungs, they can cause serious interference with breathing, which can lead to death. Blood clots are treated with blood-thinning drugs that may need to be taken for an extended period. (<3%)
9. Other bleeding either during or after surgery. The chances of requiring a blood transfusion or use of blood products are extremely unlikely during this procedure. These risks include, but are not limited to bleeding, which may require the use of blood or blood products, infection, stroke, heart attack or death. If needed, blood and/or blood products have the following general risks: reactions resulting in itching, rash, fever, headache or shock; respiratory distress (shortness of breath); kidney damage; systemic infection; exposure to blood borne viruses including hepatitis (an inflammatory disease affecting the liver) and Human Immunodeficiency Virus (HIV, the virus that causes AIDS); and death. Alternatives to transfusion include the use of devices that filter and return blood lost in surgery to me or by providing medications that boost my blood count prior to an elective procedure. Bleeding and/or severe anemia could put my life in danger or cause permanent brain damage. I understand that substitutes for blood or plasma might not work well enough. Blood and/or blood products might offer the only chance to preserve my life.

   ☐ I refuse the transfusion of blood and/or blood products and understand that I will be asked to sign a separate form entitled, Release from Liability for Refusal of Blood Transfusion.

10. Damage to nerves from pressure or positioning of the arms, legs or back during the surgery. This type of nerve damage can cause numbness, weakness, paralysis and/or pain. In most cases these symptoms are temporary, but in rare cases they can last for extended periods or even become permanent. (<2%)

11. Pressure sores on the skin due to positioning. (<2%)

12. Burns caused by use of electrical equipment that may be needed to stop bleeding or by other equipment. (<1%)

13. As with all surgeries conducted under general anesthesia, there is a very small risk of heart attack, stroke and death, even in healthy patients.

14. Occasionally, small pieces of instruments used during surgery may break off and be left in the surgical area. Usually these are small pieces or shavings from a drill bit (used to get through bone) or the tip of an electrocautery instrument (used to stop bleeding). Generally, this material causes no harm. However, there may be limitations to the use of MRI in the future. Also, other material used during surgery can be left behind unintentionally (cotton pledgets, plastic drains, needle tips). Sometimes additional surgery is required to remove this material.

15. Every effort is made to operate on the part of the spine that pre-operative examination and images (x-ray, CT myelogram or MRI) have indicated is the cause of your problem. However, a number of factors (congenital spine abnormalities, normal anatomical variations, obesity) can result in a procedure performed at a different anatomic level than originally planned. If recognized during the exposure of the spine, the procedure will be redirected to the appropriate spinal elements. If not recognized until after surgery, a second procedure may be necessary to accomplish the goal of the original surgery.

16. Other risks, if any:_____

Alternatives: I understand that I have the choice NOT to undergo the recommended procedure or any procedure. On occasion, conservative therapy or non-surgical treatment, such as medication, rest, physical therapy, manipulation, traction, injection and/or massage, may relieve the symptoms associated with a herniated disc. I acknowledge that the alternative therapies that may be medically acceptable treatments for my condition, if any, have been thoroughly discussed with me.

If my procedure is to be performed in an Ambulatory Surgical Facility (ASF), the comparative risks, benefits and alternatives associated with performing the procedure in the ASF instead of a hospital have been fully explained to me.

Teaching Facility: I understand that the facility may be a teaching facility. The health care team may include residents, fellows, students and skilled healthcare professionals. These team members may perform all or parts of my procedure under the supervision and guidance of my physician(s). I understand my physician(s) will perform or be present for the key portions of the surgery. Who will participate and in what manner will be decided at the time of procedure and will depend on the availability of individuals with the necessary expertise and on my medical condition. If an accidental exposure to my blood or body fluids occurs to staff during the surgery or procedure, I agree to blood tests for hepatitis B, hepatitis C and HIV.

I understand that the physician(s) or others may choose to photograph, televise, film, or otherwise record all or any portion of my procedure for medical, scientific, or educational purposes. I consent to the photographing, televising, filming, or other forms of recording the procedure(s) to be performed, including appropriate portions of my body, body functions or sounds, provided my identity is not revealed. I understand and agree that 1) any photographs, films, or other audio or visual recordings created will be the sole property of the facility: and 2) the facility or any appropriate staff member may edit, preserve, or destroy all or any part of the photographs, films, or other audio or visual recordings. Such recordings are not part of the medical record and I understand I cannot obtain a copy.

I authorize the disposal or retention, preservation, testing, or use for scientific, educational, or other purposes for all or any portion of specimens, tissues, body parts, or other things, including prostheses and medical/surgical appliances, that may be removed from my body.

I understand that if any medical device defined by federal regulations is implanted in a patient's body, the facility is required by law to report to the manufacturer the name, address and social security number of the patient and the description and identity of the device.

I understand the hospital may require that all jewelry and/or body piercing hardware be removed prior to surgery.

MY SIGNATURE BELOW ACKNOWLEDGES THAT:

1. **I have read (or had read to me), understand and agree to the statements set forth in this consent form.**
2. **A physician or physician's representative has explained to me all information referred to in this consent form. I have had an opportunity to ask questions and my questions have been answered to my satisfaction.**
3. **All blanks or statements requiring insertion or completion were filled in before I signed.**
4. **No guarantees or assurances concerning the results of the surgery have been made.**
5. **I am signing this consent voluntarily. I am not signing due to any, coercion or other influence.**
6. **I understand that I can withdraw my consent at any time prior to the procedure.**
7. **I herby consent and authorize Dr._____ ("my physician(s)") and/or those associates, assistants and other health care providers designated by my physician(s) to perform a microdiscectomy and remove as much disc and other material as deemed necessary in their judgment. I understand that during the course of the surgery, conditions may become apparent that require my physicians or their designees to take steps or perform additional procedures that they believe are medically necessary to achieve the desired benefits or for my well-being, including but not limited to, the administration of blood and/or blood products and/or the extension of the procedure to levels of the spine above or below the levels originally identified. I authorize and request my physician(s) or their designees to perform whatever medical acts or additional procedures they, in the exercise of their sole professional judgment, deem reasonable and necessary, and I waive any obligation on their part to stop or delay the continuation of my surgery in order to obtain additional consent.**

_____ _____

Witness Signature of patient or authorized representative

_____ _____ _____

Date Time Relationship to patient if signer is not patient

I have explained to the patient signing above all the information contained in this consent form. I have given no guarantee or assurance as to the results that may be obtained.

_____ _____ _____

Date Time Signature of Physician or Representative

UPMC LIFE CHANGING MEDICINE

PATIENT IDENTIFICATION

LUMBAR OR THORACIC POSTERIOR MICRODISCECTOMY CONSENT

INTERPRETER'S STATEMENT

Execute if an interpreter is provided to assist the individual in understanding this informed consent form:

I have translated the information and advice presented orally to the individual to be treated by the person obtaining this consent.

In addition, I have sight translated the consent form (read it aloud in his/her language). To the best of my knowledge and belief he/she understood this explanation.

_____
Cyracom ID (if applicable)

_____
Print Name

_____
Signature (Not required if a Cyracom Interpreter Was Used)