



ORTHOPEDIC CENTERS OF COLORADO

Denver Spine Surgeons

## Addendum to Informed Consent Form

### – Spinal Surgery

I understand that not having surgery may result in progressive symptoms such as continued or worsened pain and/or progressive nerve damage resulting in weakness, paralysis, loss of bladder/bowel control.

#### Spinal Surgery Risks:

Persistent/Worsened Symptoms	Damage to Spinal Cord, <b>Nerve Roots</b> , Major Vessels	
Damage to Bowel	<b>Dural Leak</b> requiring repair and/or extending hospital stay	
Paralysis	Long-term Treatment of Infection	
Bladder/Sexual Dysfunction	Adjacent Level Disease Requiring Surgery	
Re-operation	Spinal Instability and Further Degeneration of Spine	
Failure of fusion	Pain at Bone Graft Site	<b>Recurrent/New Disease</b>

#### Hardware Risks:

Removal of Hardware	Movement of Hardware	Failure of Hardware
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#### Pain Medications

I understand that narcotic analgesics may be necessary after surgery and that the use of these medications can be addictive or habit forming. I anticipate being off these medications approximately 3 – 6 months after surgery. I understand that I will not be prescribed narcotic analgesics 3 - 6 months after surgery and agree to this without reservations. I understand that I will be required to sign a pain contract.

**Do not sign unless you have read and thoroughly understand this form!**

#### Patient's Consent

I have read and fully understand this spine specific addendum to the consent form, and understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in the consent form.

\_\_\_\_\_  
Patient Signature/Surrogate (indicate relationship)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

#### Physician's Statement

I have explained the contents of this document to the patient or Surrogate Decision-maker and have answered all the patient's questions. To the best of my knowledge, the patient or decision maker understood the discussion and consents to the procedure.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

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

*Patient Label*