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

**Hardware Risks:**
- Removal of Hardware
- Movement of Hardware
- Failure of Hardware

**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 months after surgery. I understand that I will not be prescribed narcotic analgesics 3 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