Patient Label

TOURO INFIRMARY

INFORMED CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE (INCLUDING BLOOD) AND 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 general nature of the procedure/treatment/surgery, (2) the nature of your condition, (3) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor, and (4) reasonable therapeutic alternatives, risks associated with such alternatives, and 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 the 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 it.

1. Patient Name: _____

2. Treatment/Procedure:

Left shoulder	Yes ☐	No ☐
Right shoulder	Yes ☐	No ☐

(a) Description, nature of the treatment/procedure: Arthroscopic versus open shoulder capsulolabral repair: This procedure surgically tightens the structures at the front and/or back of the shoulder joint either through a large cut or through multiple little cuts.

(b) Purpose: The purpose of the surgery is to stabilize the ball within the shoulder socket. If the ball remains in the socket, the pain associated with recurrent shoulder dislocations should be eliminated or improved.

Blood and/or Blood Components (This section is to be completed only if the need for blood or blood components is anticipated.)

If transfusion is anticipated, the patient checks one of the boxes below and initials to authorize transfusion:

- If the **YES** box is checked and initialed by the patient, consent includes transfusion of blood and blood components, and the material risks in section 4(e) apply.
- If the **NO** box is checked and initialed by the patient, Touro's Refusal of Care Form (# 5110) must also be completed and placed on the chart.

❒ YES _____ Pt. Initial ❒ NO _____ Pt. Initial

3. 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 2 is indicated and recommended: Shoulder Instability: The shoulder joint is made up of a ball and a socket. The rotator cuff muscles/ tendons, capsular ligaments, and labrum surround the shoulder joint and help keep the ball within the socket. If one or more of these anatomical structures are torn or stretched, the ball may dislocate out of the socket.

If other problems with the shoulder are discovered during the surgery, they will be corrected as well. These procedures may include one of the following: biceps tenotomy (or release), biceps tenodesis (or reattachment to the arm bone), biceps tendon debridement, labral debridement, chondroplasty (or shaving of cartilage), or rotator cuff repair

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 to 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) Risks (if any) as determined by your doctor or additional risks (if any) 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, labral 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, recurrent instability

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

   (c) Risks generally associated with any surgical treatment/procedure, including anesthesia are: death, brain damage, disfiguring scars, quadriplegia (paralysis from neck down), paraplegia (paralysis from waist down), the loss or loss of function of any organ or limb, infection, bleeding, and pain.

   (d) Risks associated with the **Transfusion of Blood and Blood Components** include: fever; transfusion reaction which may include heart failure; kidney failure or anemia; hepatitis; AIDS (acquired immune deficiency syndrome); and other infections.

5. Reasonable therapeutic alternatives, risks associated with such alternatives, or risks associated with no treatment, 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, bracing, and alteration of your lifestyle.

6. Acknowledgments:

   (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 expressed 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

Print name of authorized physician

(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.

Signature of Physician / Date / Time

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 appropriate 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 2 of this consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Patient or Authorized Person / Date / Time

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

and the relationship to the patient: _____

Witness / Date / Time

ADDENDUM:

If other problems with the shoulder are discovered during the surgery, they will be corrected as well. These procedures may include one of the following: biceps tenotomy (or release), biceps tenodesis (or reattachment to the arm bone), biceps tendon debridement, labral debridement, chondroplasty (or shaving of cartilage), or rotator cuff repair