CONSENT AND REQUEST FOR SURGERY/PROCEDURE

I, _____(patient or authorized representative), authorize _____ to perform the following operation/procedure (no abbreviations/acronyms):_____
I understand the reason for the procedure is _____

ALTERNATIVES: _____

RISKS: This authorization is given with the understanding that any operation or procedure involves some risks and hazards. The more common risks include infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, pneumonia or death. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular operation include, but are not limited to:_____

- Other qualified healthcare practitioners may perform important tasks in my procedure (i.e. opening, closing, removing tissue) based on their scope of practice under the direct supervision of my physician.
- Medical observation or participation may occur during my procedure by healthcare team members, students and designated sales representatives under the direct supervision of my physician.
- Any tissue, foreign body or prosthesis surgically removed may be retained for examination and disposed of by The Orthopaedic and Spine Center of Southern Colorado in accordance with accustomed practice and as required by regulation.
- The Orthopaedic and Spine Center of Southern Colorado will release applicable health information to device manufacturer(s) per state or federal regulations in order to track any implanted device in case of a recall or failure.

Pregnancy: I understand that medications and anesthesia given to me during my surgery may cause damage to an unborn child. If there is any chance I may be pregnant, I understand I need to notify my surgeon and anesthesiologist immediately. As a woman of childbearing age, I also consent to a pregnancy test being performed prior to my procedure. *I may refuse the pregnancy test by initialing at the end of this paragraph.* By doing so, I understand I also assume all risk for any damage related to this surgery or anesthesia that may occur to any unborn child I may be carrying. _____.

Additional Procedures: If my physician discovers a different, unsuspected condition at the time of surgery that may prove to be life-threatening if not taken care of immediately, I authorize him/her to perform such treatments as deemed necessary. While we are honored to serve you and provide free initial evaluation, free surgery, and free post-operative evaluation, if any complications arise where we need to take you back into surgery or to the hospital, these facility and procedure fees will fall to patient responsibility.
I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the conditions. My physician has also discussed with me the probability of success of this procedure as well as the probability of serious side effects.

Recuperative Period: My physician has discussed with me the probable length of the recuperative period and problems I may encounter during my recovery

Blood Transfusion: ☐ **N/A** ☐ **I agree** ☐ **I do not agree** to the use of blood or blood products during and after the procedure as needed based on the explanations of the risks, benefits, and expected results (See information sheet).

*****PATIENT RESPONSIBILITY*****
I understand that Free Hand Surgery Day provided by the physicians of The El Paso County Touching Hands Project exclusively includes my initial consultation, surgery, and 90-days post operative treatment. In the event complications arise, I understand all service and facility fees may fall to patient responsibility for payment.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM

If you have questions as to the risks or hazards of the proposed surgery or treatment, or if any questions concerning the proposed surgery or treatment, ask your surgeon now BEFORE SIGNING THE CONSENT FORM. You have the right to withdraw consent for this procedure at any time before it is performed.

PATIENT'S CONSENT: I have read and fully understand this consent form and the information my physician/LIP gave me. I understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction or if I do not understand any of the words contained in this form. By my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Patient or Authorized Representative_____Date_____Time_____

Relationship (if other than Patient)_____Witness_____

PHYSICIAN'S AFFIRMATION: I have explained the operation / procedure anticipated benefits, indications, alternatives, and material risks pertinent to this procedure. I have answered my patient's questions. The patient has been adequately informed and consented.

Signature of Physician:_____Date:_____Time:_____

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Medical History and Physical Exam

Diagnosis _____

History of Presenting Illness _____

Significant Past Medical History

Allergies	☐ None	or list	_____
Medical Problems	☐ None	or list	_____
Medications	☐ None	or list	_____
Prior Surgeries	☐ None	or list	_____
Anesthesia Problems	☐ Y	☐ N	
Habits Smoking	☐ Y	☐ N	
Drugs	☐ Y	☐ N	
Alcohol	☐ Y	☐ N	

Review of Systems

1. Constitutional Symptoms (fever, chills, weight loss, etc.)	☐ None or list	_____
2. Eyes, Ears, Nose, Mouth, Throat (Visual Changes, Hearing loss, etc.)	☐ None or list	_____
3. Cardiovascular (chest pain, palpitations, edema, varicose veins, etc.)	☐ None or list	_____
4. Respiratory (cough, shortness of breath, wheezing, etc.)	☐ None or list	_____
5. Gastrointestinal (abdominal pain, heartburn, etc.)	☐ None or list	_____
6. Genitourinary (frequent urination, urgency, etc.)	☐ None or list	_____
7. Musculoskeletal (Pain or swelling, restricted motion, etc.)	☐ None or list	_____
8. Integumentary (rash, sores, blisters, etc.)	☐ None or list	_____
9. Neurological (numbness, tingling, burning, loss of sensation, etc.)	☐ None or list	_____
10. Psychiatric (Nervousness, anxiety, depression, etc.)	☐ None or list	_____
11. Endocrine (Heat or cold intolerance, excessive thirst, etc.)	☐ None or list	_____
12. Hematologic/lymphatic (abnormal bleeding, etc.)	☐ None or list	_____
13. Allergic/immunologic (Allergic reactions, recurrent infections, etc.)	☐ None or list	_____

Pertinent Findings

HEENT	WNL	or _____
Heart	WNL	or _____
Lungs	WNL	or _____
Abdomen	WNL	or _____
Extremities	WNL	or _____

Impression _____

Mental Status/Decision Making Competent ☐ Yes ☐ No

Procedure _____

(include site and type of anesthesia planned)

Signature _____ Date _____

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Surgery Date: _____

Post-Operative Appointment: _____

Welcome to The Orthopaedic and Spine Center of Southern Colorado. Information about our Surgery Center, how to prepare for your surgery, our contact information and all information detailed within this packet can also be found on our website. Please visit our website at https://www.epctouchinghandsproject.org/patient-forms/

Please read the following for important information regarding your surgical procedure.

- **We, at the surgery center, will notify you of your arrival time the day before your procedure between 2pm and 4pm. If you have any questions or concerns about your arrival time, please call The Orthopaedic and Spine Center of Southern Colorado at 719.282.8888.**

- Registration personnel from The Orthopaedic and Spine Center of Southern Colorado may call to review your insurance information. You may call directly at 719.282.888 if that is more convenient.

- A nurse will also call you regarding your procedure prior to the day of your procedure. The nurse will ask you questions about your medications, dosages, medical and surgical history. Please have this information available. You may call the nurse directly at 719.208.7991.

- At the time of your discharge, it is **required** that a responsible adult over the age of 18 accompany you. **You may not drive for 24 hours following anesthesia.** If you receive general anesthesia or IV sedation for your procedure, you must have a responsible adult over the age of 18 remain with you for 24 hours following the procedure. (This excludes local procedures). Please tell your accompanying party that they need to be available as soon as you are ready for discharge, they should not make any other appointments on the day of your procedure.

- Some surgical procedures and/or anesthetics may temporarily affect your breathing in the immediate post-operative period. Because of this, you may be required to receive supplemental oxygen for a few days while the effects of the surgical procedure / anesthetic wear off. We have contracted with a local, private respiratory care company that will provide you with home oxygen for up to 7 days. When they arrive at your home, you may be required to pay a fee of $195. If you currently utilize oxygen and have a tank at home, please feel free to bring your tank with you the day of surgery to mitigate the potential for an additional charge.

  * You will only be required to have oxygen at home if your oxygen levels are below normal after your procedure.*

- Call your surgeon's office if you develop a cold, sore throat, fever or any other illness that occurs within 48 hours of your surgery.

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DIETARY RESTRICTIONS:

The following instructions are very important for your safety.

If you do not follow these instructions, your procedure may be cancelled or delayed.

- **Do not eat or drink anything after midnight the night before your procedure.**
- No gum, breath mints, hard candy or tobacco after midnight.
- Brush your teeth, rinse and spit without swallowing the water.
- Your prescription medications will be reviewed during the interview and those indicated may be taken with sips of water on the day of surgery.

WHAT TO BRING:

- ☐ A photo ID
- ☐ Bring a case for glasses and dentures.
- ☐ Reading glasses, if needed
- ☐ Bring any slings, braces or other medical equipment already issued or previously in use.
- ☐ Bring your CPAP or other device if you have sleep apnea and use one at home.
- ☐ Bring your inhaler if you have asthma, COPD or any other condition that requires you use one

ADDITIONAL INSTRUCTIONS:

- ☐ Do NOT take any medications containing NSAIDs (Aspirin, Ibuprofen, Advil, Motrin, Naproxen, Aleve, Mobic), Fish Oil, Vitamin E, Omega Fatty Acids, CO-Q-10, herbs, or weight loss supplements for seven (7) days prior to your procedure. If you have taken them, please contact your surgeon right away.
- ☐ If you take any blood thinning medications for your heart such as Aspirin, Coumadin, Plavix or Xarelto, please contact your cardiologist or primary care physician for guidance regarding when you should stop taking these medications.
- ☐ Remove all jewelry and piercings
- ☐ Leave ALL jewelry and valuables at home. The Center is not responsible for valuables.
- ☐ Wear loose-fitting comfortable clothes and shoes.
- ☐ Please do NOT apply makeup, deodorant, creams, or lotions. If you are having a procedure on any extremity (i.e. Arm or leg), remove nail polish from the operative side.
- ☐ If you think you may be pregnant, please call the surgery center right away at 719.282.8888

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DRIVING DIRECTIONS:

Our address is 4110 Briargate Parkway, Suite 200, Colorado Springs, CO 80920

- From the North: Take I-25 South, take exit 151 toward Briargate Parkway. Merge onto Briargate Parkway make a left on Memorial Hospital Drive. The facility will be on the left.
- From the South: Take I-25 North, take exit 151 toward Briargate Parkway. Merge onto Briargate Parkway make a left on Memorial Hospital Drive. The facility will be on the left.
- From Powers: Take powers, exit at 151 toward Briargate Parkway, head west, turn right on Memorial Hospital Drive. The facility will be on the left.

The Orthopaedic and Spine Center of Southern Colorado does not discriminate on the basis of race, color, national origin, age, or disability; in admission of, access to, treatment, or employment in, its programs and activities.

To obtain information about Advanced Medical Directives, please see our website at www.jointandspineasc.com and click on the "Advanced Directive" icon or call Colorado Healthcare at 1- 800-658-8898