AUTHPR

KYPHOPLASTY / VERTEBROPLASTY CONSENT FORM

I hereby authorize Dr. _____ and/or such assistants selected by him/her to perform Kyphoplasty/Vertebroplasty procedure on (pt Name)_____. This procedure involves the insertion of a needle through the skin and into the vertebrae. A catheter with a balloon will then be inserted and the balloon will be inflated to elevate the compression. Next, a surgical bone cement called polymethylmethacrylate will be injected into the bone.

I authorize the use of local anesthesia as well as conscious sedation to decrease discomfort during the procedure.

I acknowledge the risks of the above procedure, which include:
1) Infection of the skin, tissue or bone
2) Bleeding which could require surgical intervention
3) Allergic reaction to the cement or medications
4) Migration of the cement outside the bone which could result in nerve damage, paralysis or clots to major organs such as lungs, brain, liver and kidneys.

I acknowledge that there is no guarantee of a good outcome from this or any other procedure. However, I understand that the doctor feels the potential benefits outweigh the risks of this procedure.

I acknowledge that the doctor has explained to me any possible alternative treatments or procedures that may pertain, including arterial Doppler, MRI, CT and surgery.

I also acknowledge that I have received explanation of any possible alternative treatments.

All of my questions regarding the procedure, the risks, the potential complications, and the alternatives have been answered to my satisfaction.

	/	/	
Patient's Signature		Date	Time
	/	/	
Witness		Date	Time
	/	/	
Relative		Date	Time
	/	/	
Physician		Date	Time

BAPTIST. Memorial Hospital Golden Triangle

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Form # 18-137.6 (04/04)

▼ Addressograph / Patient Label ▼