DR. CHRIS LANSFORD

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Form “C-E”
Consent for Excision of Branchial Cleft Cyst or Fistula

ONLINE: SCAN QR & SELECT FORM “C-E”

CONSENT FOR SURGERY / OPERATION / PROCEDURE(S)

1. I authorize the performance of the following operation / surgical procedure(s)

_____

_____

_____

_____

to be performed upon

_____

by and under the direction of Dr(s).

_____

2. My physician(s) has fully explained to me the condition requiring treatment and the nature, purpose, risk and benefits of the operation(s) / procedure(s), possible alternative methods of treatment, including non-treatment, and the possibility of complications. Supplementary and reinforcing information has been made available at DoctorLansford.com. I was given the opportunity to ask questions and any such questions were answered to my satisfaction. No guarantee or assurance has been given by anyone as to the results that may be obtained. I am aware that the practice of medicine and surgery is not an exact science.

3. Surgical operations and special diagnostic or therapeutic procedures all involve RISKS OF COMPLICATIONS, SERIOUS INJURY, OR DEATH, from both known and unknown causes. Therefore, except in cases of emergency or exceptional circumstances, these operations and procedures will not be performed unless I have had an opportunity to discuss them with my physician. I have the right to consent to or refuse a proposed operation or special procedure.

4. My consent is given with the understanding that any operation or procedure, including anesthesia, involves risks and hazards.

Risks of surgery, in general, include, but are not limited to:

- Injury to anatomic structures near the surgical site is possible.
- Infection can occur, requiring antibiotics and further treatment.
- Bleeding could occur and may require a return to the operating room and/or blood transfusion(s). Bleeding is more common if you have been taking blood thinning drugs such as warfarin (Coumadin), clopidogrel (Plavix), dipyridamole (Persantine), rivaroxaban (Xarelto), aspirin or aspirin-like drugs, including ibuprofen (Advil, Motrin), naproxen (Aleve), and others, or if your blood does not clot normally. Bleeding is more common with high blood pressure.
- Small areas of the lung can collapse, a condition known as atelectasis, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Risk of wound infection, chest infection, heart and lung complications, and thrombosis (blood clots) is increased in individuals who smoke, have diabetes, or who have poor nutritional status.
- A heart attack (myocardial infarction) could occur due to the strain on the heart.
- A stroke (cerebrovascular accident) could occur.
- Blood clot in a vein (venous thrombosis) causing pain and swelling could occur. In rare cases part of the clot may break off and go to the lungs (pulmonary embolism).
- Damage to teeth or dental restoration is possible.
- Urinary retention after surgery may occur.
- Death as a result of this procedure is possible.

Additional procedure-specific risks include, but are not limited to:

- The pouch may not be found.
- A fistula (track) may develop to the skin and food/fluids may come out of the neck wound.
- The pouch may reform.
- Injury to nearby nerves may occur. Nerve injury may cause numbness, muscle weakness, or pain in the area of the affected nerves. Nerve injury may be partial or complete, and temporary or permanent. This may include:
    - Injury to or sacrifice of the great auricular nerve, which may cause numbness or an abnormal sensation of the skin on or around the ear on the operative side.
    - Injury to the facial nerve, which controls the muscles of the face, may occur on the operative side. This may result in weakness or paralysis of some or all of the face muscles, and may be temporary or permanent. Specifically, injury to the marginal mandibular branch of the facial nerve, can impair movement of the lower lip.
    - Injury to the hypoglossal nerve, which can cause impairment in movement of the tongue including effect on speech and eating. This may be partial or complete, and temporary or permanent.
    - Injury to the lingual nerve, which may cause an alteration of taste and/or numbness of the tongue on the operative side.
    - Injury to the left or right phrenic nerve, which may cause breathing and/or circulation difficulties.
    - Injury to the spinal accessory nerve (cranial nerve 11), which may cause shoulder pain or movement problems on the operative side.
    - Injury to the laryngeal nerves to the vocal cords, which may cause changes in the voice and/or swallowing.
    - Development of First Bite Syndrome, which is associated with cheek/jaw pain for the first bite of a meal.
    - Injury to the superior cervical sympathetic chain, causing Horner's syndrome, involving drooping of the eyelid, construction of the pupil, and less production of sweat and tears on the affected side.
- Damage to major blood vessels may occur. This may require further surgery or blood transfusion. This may cause a stroke (cerebrovascular accident) with major neurologic injury.
- If dissection is undertaken near the internal jugular vein in the low neck, a chyle/lymphatic fluid leak at or around the thoracic duct may cause lymph fluid to build

up which may need drainage or additional surgery.

5. I consent to the performance of operations or other procedures in addition to or different from those now contemplated whether or not arising from presently unforeseen conditions, including the implantation of medical devices, which the above named physician(s) or his/her associate(s) or assistant(s) may consider necessary or advisable in the course of the operation.

6. I understand the risks, benefits, and alternatives to the type and method of anesthesia or sedation recommended, and I consent to the administration of such anesthesia as may be considered necessary or advisable by the physician(s) for this surgery / procedure.

7. I consent to the taking of photographs or video recordings that document conditions, treatments or procedures and understand that such images may be used for medical, research, professional certification, or teaching purposes. I understand that I am not allowed to take pictures or make video or audio recordings of my care, other patients, facility employees, providers, or students.

8. I consent to the presence of observers in the operating room, such as students, medical residents, medical equipment representatives, or other appropriate parties approved by my surgeon(s).

9. I consent to the disposal of any human tissue or body part which may be removed during the surgery / procedure(s).

10. I consent to pathological review of any tissue removed by the surgeon as he deems clinically appropriate. Examination of the tissue will then be performed and a report will be issued.

11. If complications arise, I agree to be admitted to the hospital of my surgeon's choice.

12. I have been advised that there is a possibility of damage to teeth during surgery and administration of anesthesia, particularly if the teeth are weak, loose, decayed or artificial, and I waive any claim for damage to teeth as a result thereof.

13. I understand that, unless instructed otherwise, I am required to have a responsible adult accompany me after my surgery / procedure(s) and that I will be released to that person's custody, and must rely upon him/her for my return home and supervision, as instructed.

14. I understand that if I am pregnant, or if there is the possibility that I may be pregnant, I must inform the surgeon and medical staff immediately since the scheduled surgery / procedure(s) could cause harm to my (unborn) child or myself.

15. If I am not the patient, I represent that I have the authority of the patient whom, because of age or other legal disability, is unable to consent to the matters above. I represent that (a) I have the full right to consent to the matters above; (b) I agree to release, indemnify, and hold harmless the surgical facility, its employees, agents, medical staff, partners, and affiliates from any liability or cost arising out of my lack of adequate authority to provide the consent set forth herein.

16. I understand that Illinois Administrative Code, Title 77, Chapter 1, Section 697.120, permits the facility to perform a blood test for HIV (the AIDS virus) on any patient during whose treatment a health care professional sustains a puncture, mucous membrane or open wound exposure to a patient's blood or other bodily fluids. A test for Hepatitis B and C may also be drawn.

17. I have not had anything to eat or drink since _____.

18. Advance Directives – Living Will – Health Care Proxy

I understand that Advance Directives and Living Wills are NOT honored at a surgery center or clinic, and in the event of an emergency or life threatening situation, advanced cardiac life support will be initiated in every instance and patients will be transported to a facility providing a higher level of care.

[ ] I have provided the medical staff with my Advance Directive/Living Will/ Health Care Proxy.

[ ] I have an Advance Directive/Living Will/Health Care Proxy but did not provide it to the medical staff.

[ ] I do not have an Advance Directive/Living Will/Health Care Proxy.

[ ] I wish to have information on how I can obtain an Advance Directive/ Living Will/Health Care Proxy.

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGMENT THAT:

1. I have read, understand and agree to the foregoing;
2. The proposed surgery / procedure(s) have been satisfactorily explained to me and that I have all of the information that I desire;
3. I hereby give my authorization and consent, and;
4. All blank spaces on this document have either been completed or crossed off if they do not apply prior to my signing.

_____ _____

SIGNED DATE & TIME

_____ _____

WITNESS DATE & TIME

_____

WITNESS' RELATIONSHIP TO PATIENT

SURGEON'S ATTESTATION: Prior to the procedure, I discussed the condition requiring treatment and the nature, purpose, risks, and benefits of the operation(s), surgery/procedure(s), possible alternative methods of treatment, including non-treatment, and the possibility of complications with my patient or the patient's authorized representatives. I provided my patient or his/her representative with the opportunity to ask questions and answered all questions to their apparent satisfaction. I have reviewed the surgical consent form and verified that the planned surgery/procedure is accurate. Surgeon's initials:_____

TRANSLATOR'S STATEMENT, IF APPLICABLE: I have verbally translated this consent into (applicable language) _____ for the benefit of the patient or his/her authorized representative who understands said language better than English. To the best of my ability, I believe the patient or his/her representative understands these statements, as witnessed by their signature on the consent form.

Translator's initials:_____

You may find more information at DoctorLansford.com