

Lumbar Laminectomy for Discectomy

Facility:

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: M F

A. INTERPRETER / CULTURAL NEEDS

- An Interpreter Service is required? Yes No
 If Yes, is a qualified Interpreter present? Yes No
 A Cultural Support Person is required? Yes No
 If Yes, is a Cultural Support Person present? Yes No

B. CONDITION AND TREATMENT

The doctor has explained that you have the following condition: *(Doctor to document in patient's own words)*

.....

.....

This condition requires the following procedure/treatment/investigation. *(Doctor to document - include site and/or side where relevant to the procedure)*

.....

.....

The following will be performed:

A Lumbar Laminectomy for Discectomy is performed to remove a prolapsed disc or disc fragments to relieve pressure on the spinal nerve roots or spinal cord.

An x-ray will be taken during surgery and used to confirm the correct levels of the spine.

A cut is made in the middle of the back, over the site of the prolapsed disc. The muscles are stripped from the back of the spine. The bones on the back of the spine (spinous process and laminae) are removed from the spine.

Further bone and ligament are removed from the spine to identify the disc.

Once the prolapsed disc is identified, the prolapsed disc or disc fragments are removed from the spine.

A small plastic tube (drain) may be inserted to allow any residual fluid to be drained away. This will be removed within 24 – 48 hours.

The cut is closed with stitches or staples.

C. RISKS OF A LUMBAR LAMINECTOMY FOR DISCECTOMY

There are some risks/complications with this procedure/treatment/investigation.

Common risks include;

- Infection. This may need antibiotics and further treatment.
- Minor pain, bruising and/or infection from IV cannula site. This may require treatment with antibiotics.

- Bleeding. If bleeding occurs further surgery may be required. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Asprin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).
- Small areas of the lung may collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increase risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.

Uncommon risks include;

- A heart attack because of the strain on the heart.
- Stroke like complications which can cause weakness in the face, arms and/or legs. This may be temporary or permanent.
- Clots in the leg (deep vein thrombosis or DVT) with pain and swelling. Rarely part of this clot may break off and go into the lungs.
- Nerve root injury. This may be temporary or permanent.
- Injury to the covering of the spinal cord. This may require further surgery.
- Deterioration of other discs. This may require further surgery.
- Ongoing persistent back and leg pain, with possible leg numbness due to nerve damage from compressed nerve roots. This may require further surgery.
- Leakage of cerebrospinal fluid. This may need further surgery.
- Visual disturbance. This may be temporary or permanent.
- Paraplegia. This may require further surgery. This may be temporary or permanent.

Rare risks include;

- Injury to major blood vessels. This will require further urgent surgery.
- Death is very rare due to this procedure.

D. SIGNIFICANT RISKS AND PROCEDURE/TREATMENT/INVESTIGATIONS/OPTIONS

(Doctor to document in space provided. Continue in Medical Record if necessary.)

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E. RISKS OF NOT HAVING THIS PROCEDURE

(Doctor to document in space provided. Continue in Medical Record if necessary.)

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F. ANAESTHETIC

This treatment/procedure/investigation may require an anaesthetic. *(Doctor to document type of anaesthetic required)*

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G. PATIENT CONSENT

I acknowledge that the doctor has explained;

- my medical condition and the proposed procedure/treatment/investigations, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me.
- the anaesthetic required for this procedure/treatment. I understand the risks, including the risks that are specific to me.
- other relevant procedure/treatment options and their associated risks.
- my prognosis and the risks of not having the procedure/treatment.
- that no guarantee has been made that the procedure/treatment will improve my condition even though it has been carried out with due professional care.
- the procedure may include a blood transfusion.
- tissues and blood may be removed and could be used for diagnosis or management of my condition, stored and disposed of sensitively by the hospital.
- if immediate life-threatening events happen during the procedure, they will be treated accordingly.
- a doctor other than the Specialist Neurosurgeon may conduct the procedure. I understand this could be a doctor undergoing further training.

I have been given the following Patient Information Sheets;

- ◆ **About you Anaesthetic**
- ◆ **Lumbar Discectomy**
- I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure/treatment/ investigations and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand I have the right to change my mind at any time before the procedure/ treatment/investigation, including after I have signed this form but, preferably following a discussion with my doctor.

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

Name of Patient/
Substitute decision
maker and relationship:

Signature:.....

Date:.....

Substitute Decision-Maker: Under the *Powers of Attorney Act 1998 and/or the Guardianship and Administration Act 2000*. If the patient is an adult and unable to give consent, an authorised decision-maker must give consent on the patient's behalf.

H. DOCTOR'S STATEMENT

I have explained to the patient all the above points under the Patient Consent section (G) and I am of the opinion that the patient/substitute decision-maker has understood the information.

Name of
Doctor:.....

Designation:

Signature:.....

Date:.....

Name of
Anaesthetist:.....

Designation:

Signature:.....

Date:.....

I. INTERPRETER'S STATEMENT

I have given a sight translation in

.....
(state the patient's language here) of the consent form and assisted in the provision of any verbal and written information given to the patient/parent or guardian/substitute decision-maker by the doctor.

Name of
Interpreter:

Signature:.....

Date:.....