

# Minimally Invasive Decompression for Lumbar Canal Stenosis

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:

This procedure is performed to relieve pressure on the spinal cord and nerve roots in the lower back.

A small cut is made in the back, over the site where the nerves are compressed.

Using x-ray for guidance, a tube retractor will be passed through the muscles and placed down on the spine. Through this tube, and using a microscope, bone and ligament and other material which are pressing on the spinal cord and nerves will be removed.

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 MINIMALLY INVASIVE DECOMPRESSION FOR LUMBAR CANAL STENOSIS

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.

**Uncommon risks** include;

- Bleeding. A return to the operating room for further surgery may be required if bleeding occurs. Bleeding is more common if you have

been taking blood thinning drugs such as Warfarin, Aspirin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).

- A heart attack because of the strain on the heart.
- Stroke or stroke like complications can occur which can cause weakness in the face, arms and legs. This could be temporary or permanent.
- Nerve root injury. This may be temporary or permanent.
- Injury to the covering of the spinal cord/nerve. 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.
- 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.
- 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.

**Rare risks** include;

- Paraplegia. This may require further surgery. This may be temporary or permanent.
- Death is very rare due to this procedure.

## D. SIGNIFICANT RISKS AND PROCEDURE 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

Minimally Invasive Decompression for Lumbar Canal

**Minimally Invasive  
Decompression for Lumbar Canal  
Stenosis**

Facility: .....

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Sex:  M  F

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

.....

.....

<h2 style="margin: 0;">Minimally Invasive Decompression for Lumbar Canal Stenosis</h2> <p style="margin: 0;">Facility: .....</p>	<p style="text-align: center; margin: 0;">(Affix patient identification label here)</p> <p>URN: .....</p> <p>Family Name: .....</p> <p>Given Names: .....</p> <p>Address: .....</p> <p>Date of Birth: ..... Sex: <input type="checkbox"/> M <input type="checkbox"/> F</p>
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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 your Anaesthetic**
  - ◆ **Minimally Invasive Decompression for Lumbar Canal Stenosis**
  - 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:** .....