The Jackson Clinic

INFORMED CONSENT FOR SURGERY AND/OR MEDICAL PROCEDURES

The signing of this form acknowledges your informed consent to the planned surgical medical procedure. Please read this form carefully and ask questions about anything that you do not understand. The common problems or undesired results that sometimes occur from the planned surgery or procedure have been explained to you, but if you have any questions that remain unanswered, do not sign this form until you have been satisfied that all of your questions have been answered.

1. I hereby authorize and direct **Dr. David M. Hall** or such medical associate as he/she may appoint, together with all assistants of his/hers or his/her associate's choice, to perform the following operation or special procedure:

(Name of operation or procedure)

In general terms, the purpose of the surgery or procedure is:

(Describe in lay language)

2. I have been advised that during the operation or procedure described above that the physician, may, in his/her best medical judgement, feel that some other surgical or medical procedure needs to be performed at that time that has not previously been discussed because the need for the procedure could not have reasonably been foreseen. I consent to permit the physician to exercise his/her best medical judgement and do further authorize the physician performing the surgery or special medical procedure to perform any other surgery or procedure that in his/her judgement is advisable for my well-being.
3. I have been informed that there are risks associated with the surgery or special medical procedure which is to be performed. I realize that complications can occur that could even bring about death, paralysis, or loss of use or function of a limb or organ. I have also been advised that surgical procedures may result in disfiguring scars. Risks of anesthesia have been explained to me and I have been informed that they can be as serious as those mentioned above for the surgery or medical procedure itself. An occasional, but unavoidable, risk is that people with bridges, crowns, caps, or other dental appliances, as well as people with weak, diseased, or even healthy teeth may unconsciously bite so hard that a tooth or appliance is damaged or lost. In such an event, I understand that it is not the responsibility of the surgeon or The Jackson Clinic Professional Association or the anesthesiologist, or any anesthetist to pay for damage, injury to, or loss of teeth or dental work appliances.
4. The nature and purpose of the surgery or procedure has been explained to me and I have been told of the possibility that complications may arise or develop and of the more common risks as well as possible alternatives to the proposed treatment or procedure.
5. I understand that the operating surgeon will be occupied solely with the surgery or medical procedure, and that the administration of the anesthesia is an independent professional function which will be handled by a nurse anesthetist or anesthesiologist who will be selected by the surgeon or hospital. I authorize the nurse anesthetist or anesthesiologist to administer such anesthetics as he/she may deem appropriate in my case.
6. I hereby authorize the above-named physician or his/her designated associate or assistants to obtain such additional services as he/she may deem reasonable and necessary, including, but not limited to, the services of the x-ray department, laboratory, or pathology department. If the surgery or special procedure involves removal

of tissue or parts, I authorize that they be retained or disposed of by the physician, facility or by the hospital where the procedure is performed, in accordance with their customary practices.

7. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of the proposed surgery or procedure.
8. This consent is valid until revoked by me in writing.
9. I hereby state that I have read and understood this document, that all questions about the surgery or procedure have been answered in a satisfactory manner, and that all blanks were filled in at the time of my signing.

Date: _____ Time: _____

Signature of Patient: _____

Witness: _____

I certify that all blanks in this form were filled in prior to signature and that I explained the procedure, risks, and alternatives to the patient or the authorized representative signing on behalf of the patient before requiring the patient or his/her representative to sign.

Physician: _____

Opiate Pain Management Agreement

General Surgery operations can be painful, and it may be necessary for your Surgeon to prescribe opiate pain medications. This document provides information regarding these pain medications and will used to prevent misunderstandings regarding these medications postoperatively.

- The Jackson Clinic General Surgery Department does not prescribe opiate medications other than following injury or for postoperative pain.
- The Jackson Clinic General Surgery Department does not prescribe medication for long term pain management.
- If you already see a Pain Management Specialist, or a Primary Care Physician who prescribes these drugs, please make sure that you see them before surgery to discuss your postoperative pain control plan.
- No medication refills will be available during evenings or on weekends.

I agree to the following:

- I will not take more medication than prescribed.
- I will disclose all controlled medications with The Jackson Clinic General Surgery Department.
- I will not use any illegal controlled substances while taking opiate medications.
- I understand that when I take opioids, I may experience reactions or side effects that could be dangerous. These side effects include sleepiness, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing so much that it can lead to death.
- I understand that when I take opioids, it may not be safe for me to drive a car, work machines, or take care of other people. If I feel tired, confused, or unable to function with this medication, I should not do things that would put me or other people at risk.
- I understand that usually there are other options to opioids to treat moderate to moderately severe pain, including therapy that does not involve medication. I understand that there are times when these other options may provide more pain relief with less risk. I have talked about the other options with my provider.
- I understand that using opioids to treat moderate to moderately severe pain comes with possible benefits and risks. When used correctly, opioids may help reduce pain, improve function, and improve quality of life. However, use can also lead to tolerance and dependence, which means the body needs higher and higher amounts to get the same relief and the body craves the medicine and does not feel normal without it. Taking opioids can lead to opioid use disorder which can happen when a person chooses actions they know to be harmful in order to meet the craving for opioid medicine. Using opioids requires both the provider and the patient to work together responsibly to ensure the most benefit, shortest exposure, fewest side effects, and avoid developing substance use disorder.

- I understand that opioids work to dull pain. They do not fix the actual injury and can lead to further harm due to decreasing pain, which is part of the body's response to injury. Opioids may help prevent acute pain from becoming long-lasting pain, but on the negative side, they often have side effects and may lead to long term use of opioids and development of a life-threatening opioid use disorder.
- I understand that if I become dependent on opioids, when I stop taking them, I may experience stomach pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, anxiety, and difficulty sleeping.

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- I understand that anyone can develop an addiction to opioids, but people who have had poor mental health or problems with drugs or alcohol in the past are at higher risk. I understand it is my responsibility to tell my provider if I or anyone in my family has had any of these problems.
- I understand that I must safely store and legally get rid of opioids left over after I am better. I understand that medications should always be stored in a safe place and out of the reach of children and other family members. To safely get rid of unused medication, I can take it to any police station, to some pharmacies, and other sites. A list of sites known to be available is at https://www.tn.gov/health/health-programareas/pdo/pdo/resources/r/community.html.

Patient/Guardian Signature: _____ Date: _____

Preoperative Instructions

The general surgery staff can schedule your surgery at several different facilities. Please be sure to confirm with the office where your surgery will be performed.

_____ Jackson Madison County General Hospital (620 Skyline Drive, Jackson, TN 38301). **Please call (731) 541-6919 the day after your surgery is scheduled to make an appointment for pre-anesthesia testing.** Please go over all your current prescription and over the counter medications with the pre-anesthesia team. The day before surgery you will receive a phone call regarding your arrival time. On the day of surgery please park in front of the main entrance in the large parking lot and enter through the front door and check in with the admissions desk. Please see the map included in your scheduling information. If you have any further questions, please contact the general surgery office.

_____ West Tennessee Surgery Center (700 West Forest Ave, Jackson, TN 38301 – First Floor). Please call Ms. Peggy Johnson at (731) 541-8868 the day prior to your procedure. On the day of surgery please park in garage 3 and enter through the main entrance on the ground floor. If you have any further questions, please contact the general surgery office.

_____ Jackson Clinic Vein and Vascular Center (213 Sterling Farms Dr, Jackson, TN 38305). You will be contacted by the Vein and Vascular Center, and they will go over the instructions with you over the phone. Please call the Vein and Vascular Center at (731) 422–0481 if you have any questions.

Medication Instructions

1. Diabetic Medications – Hold oral medications the morning of surgery. If you take Metformin - you may begin taking it again 2 days after surgery. If you are on insulin - Please discuss your insulin dosage with the pre-anesthesia team and follow their instructions.
2. Anticoagulant or Antiplatelet agents (Blood thinners) – stop these blood thinners on the designated number of days before surgery. **This may not be required if you are undergoing a vascular procedure.** Please confirm with the general surgery office if these need to be discontinued.
    a. Aspirin –7 days
    b. Cilostazol – 4 days
    c. Coumadin (Warfarin) – 5 days
    d. Eliquis (Apixaban) – 2-3 days
    e. Plavix (Clopidogrel) – 5 days
    f. Pradaxa (Dabigatran) – 5 days
    g. Savaysa (Edoxaban) – 1 day
    h. Xarelto (Rivaroxaban) – 3 days
    i. Zontivity (Vorapaxar) – 28 days

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3. Over the Counter Medications – Please stop all over the counter medications, herbs, and NSAIDS 7 days before your procedure (i.e., Vitamin E, multivitamin, herbal blends, BC powder, Goody's, Ibuprofen, Aleve, Motrin, Meloxicam, Celebrex, Diclofenac Sodium, etc.)

Diet Instructions

1. Nothing to eat after midnight prior to your operation (Please see below if you are undergoing a colon operation). You can have clear liquids until you arrive at the hospital. You can have coffee but **without** milk or non-dairy creamer. Please drink a carbohydrate loading beverage (i.e., Gatorade or Powerade) on the way to the hospital.
2. If you are undergoing a colon procedure, please see the bowel preparation instructions as you will start a clear liquid diet the day before surgery.

Other Instructions

1. Shower the night before and the morning of surgery. Wear loose fitting clothing to the hospital to allow room for bandages.
2. Do not use makeup, lotion, creams, powders, deodorant, perfume or hair products after your shower or the morning of surgery.
3. Jewelry, piercings, hearing aids, contacts, glasses, dentures, bridges, or partials cannot be worn into surgery.
4. No alcohol, gum, chewing tobacco, or smoking the morning of surgery.
5. Please bring a driver. You will not be able to drive yourself home after surgery. You must make plans for a responsible person to receive the postoperative information and drive you home.
6. Your postoperative appointment will be made at the time of scheduling your surgery.
7. Please call our office at (731) 422-0308 if you have any questions. We are here to help you!

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Dr. Hall's Hospital Discharge Instructions Following Laparoscopic Peritoneal Dialysis Catheter Placement

Activity

Proceed with your daily activities as tolerated but do not lift anything heavier than 10 pounds for 6 weeks. Walking following the operation is encouraged.

Diet

Eat a healthy and well-balanced diet as recommended by your Nephrologist. A separate instruction sheet will be provided if necessary.

Wound Care

The peritoneal dialysis catheter cannot get wet for the first two weeks after surgery. Please do not change the bandage or shower. You can sponge bathe as long as the dressings stay dry. The first dressing change will occur in our office at your 1 week follow up appointment. The second dressing change will be at your peritoneal dialysis training two weeks after surgery.

Follow Up and Results

Follow up in our clinic in one week for a wound evaluation and to discuss any results. If there are any problems or questions after surgery, please call our office at (731) 422-0304.

Follow up at your dialysis center in two weeks for your peritoneal dialysis catheter training.