Surgical Consent for Parathyroidectomy

Diagnosis: __________________________________________________________

Name of Procedure/Treatment:
• Parathyroidectomy (removal of one or more parathyroid glands)

Nature and purpose of proposed treatment:
• An incision is made on the neck and one or more parathyroid glands will be removed depending on the reason for the surgery

Risks common to all surgical procedures:
• Injury to a blood vessel or excessive bleeding. This may require a blood transfusion.
• Infection, which may require the use of antibiotics. In rare cases, another surgical procedure may be necessary to remove the infection.
• Complications with anesthesia. This may include nausea, vomiting, or in rare cases, death.
• Tobacco use, excessive alcohol use and obesity can increase the risk of any surgical procedure or general anesthetic. Any of these factors may substantially affect healing and can result in an increase of major complications including pneumonia, wound infection, blood clots in the legs and lungs, or death.

Risks and possible complications of the proposed treatment:
• Bleeding
• An infection, which may require you to take antibiotics. Another surgical procedure may be needed.
• Nerve damage, causing hoarseness
• Recurrent disease which may require another surgical procedure
• Pain after surgery that may require you to take pain medication
• Scars at the incision site
• Loss of parathyroid function (controls the levels of calcium and phosphorus in the body)

Risks or complications of the proposed treatment that is specific and unique to the patient: __________________________________________________________

Alternative Treatments:
• Needle biopsy
• Observation

Prognosis if the proposed treatment is NOT accepted:
• Growth may be malignant (cancer) and would be undiagnosed
• The growth may enlarge putting pressure on the esophagus (swallowing tube) and trachea (breathing tube)
• Development of weak bones that break easily
• Development of kidney stones

I understand the above information and give my consent to have the described treatment performed.

___________________________________  ________________________________
Patient Signature      Physician Signature

___________________________________  ________________________________
Date         Date

In certain procedures, your primary surgeon may feel that an assistant surgeon will be needed for the optimal conduct of the above surgical procedure. I understand that in certain procedures my surgeon may feel that an assistant surgeon will be needed.

___________________________________  ________________________________
Patient Signature       Date