Surgical Consent for Thyroidectomy

Diagnosis:

Name of Procedure/Treatment:
• Thyroidectomy (removal of part or all of the thyroid)

Nature and Purpose of proposed treatment:
• An incision is made on the neck and the growth on the gland or a portion of the gland is removed.

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 complications of the proposed treatment:
• Bleeding, requiring additional surgery
• Infection, which may require the use of antibiotics. In rare cases, another surgical procedure may be necessary to remove the infection.
• Nerve damage, causing hoarseness
• Recurrent disease, which may require another surgical procedure
• Pain after surgery, which may require the use of pain medication
• Scars at the incision site

Risks of complications of the proposed treatment specific and unique to the patient:

__________________________________________________________________________________________________
__________________________________________________________________________________________________

Alternative treatments:
• Needle biopsy
• Observation

Prognosis if the proposed treatment is NOT accepted:
• The growth may be malignant (cancer) and would be undiagnosed.
• The growth may become enlarged. This may put pressure on the esophagus (swallowing tube) and trachea (breathing tube).

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.

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Patient Signature                  Date