THYROID NODULE TREATMENT CENTER

Richard J. Harding, MD, FACS
Endocrine & General Surgeon
Board Certified Medical Director

PATIENT INFORMED CONSENT

Operation or procedure and alternatives:

I, _____, authorize Dr. Richard Harding, and assistants of his choosing to perform the procedure: Radiofrequency Ablation of thyroid nodule(s) (Left) (Right). I understand the reason for the procedure is to treat large benign nodules in order to shrink the size of nodule(s), destroy nodule function, and decrease symptoms.

Alternatives include:

1. Thyroid surgery which has potential complications of nerve injury, hoarseness, scar on neck, loss of thyroid function, hypocalcemia, anesthesia, hospital admission.
2. To not undergo procedure listed which will not improve symptoms or condition, and the disease may progress.

Patient Initials _____

Risks: This authorization is given with the understanding that any operation or procedure involves some risks and hazards. Some of the significant risks of this particular procedure are: pain, injury to thyroid, injury to surrounding structures, recurrent laryngeal nerve injury with temporary or permanent hoarseness, need for ongoing medical treatment of disease, bruising, complicate further surgery, failure to treat undiagnosed cancer, failure to improve existing symptoms, temporary pain at injection site during administration, prolonged numbness and tingling, accidental vascular injection, tumor regrowth, burn caused by the overheated electrodes, local bleeding at site of the ablation, nodule rupture. **Any compromise in airway concerns may warrant a transfer to the hospital for further therapy.**

I also understand that the more common risk of any procedure include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reaction, and pneumonia. **These risks are serious and possibly fatal.**

Patient Initials _____

Anesthesia: the administration of anesthesia also involves serious risks, most importantly a rare risk of reaction to medication causing death. This medication can cause nausea, drowsiness, and dizziness. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services.

Patient Initials _____

Additional procedure: if Dr. Harding discovers an unsuspected condition at the time of the procedure such as bleeding, I authorize him to perform such other procedures as deemed necessary except _____.

Patient Initials _____

Results not guaranteed: I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition. Repeat treatment may be indicated for recurrent growth of some nodules.

Patient Initials _____

Patient consent: I have read and fully understand this consent form. I understand I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form. I have no further questions.

Patient Initials _____

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR ANY QUESTIONS CONCERNING THEM, ASK DR RICHARD HARDING BEFORE SIGNING THIS FORM.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM

Patient name:_____

Patient signature:_____ DOB:_____

Today's date:_____

Witness:_____

Physician declaration: I have explained the contents of this document to the patient and have answered all the patient's questions; to the best of my knowledge, the patient has been adequately informed. The patient has been consented.

Physician signature: _____ Today's date:_____