McLaren Flint
Flint, MI
BARIATRIC INSTITUTE
ROUX-EN-Y GASTRIC BYPASS SURGERY INFORMED CONSENT

I, _____, having been unsuccessful in losing weight by dietary and other means, request _____ to perform the Bariatric Surgery on me for the treatment of my morbid obesity. This procedure has been explained to me, along with the alternatives and potential complications. I understand that this is a major abdominal surgery and some of the complications include, but are not limited to: infection; bleeding at the time of surgery; bleeding after the surgery; problems with wound healing; separation of the wound; pleural effusion (fluid around the lung); neuropathy (nerve pain or numbness); pancreatitis (inflammation of the pancreas); incisional hernia; adhesions (scars)inside the abdomen which may subsequently cause bowel obstruction; blood clots in the leg, pelvis or elsewhere, which can cause circulatory problems in the legs or pulmonary embolism (blood clots migrating into the heart and lungs, which can sometimes be fatal); anesthesia-related problems; heart-lung problems; the possibility of injuring the spleen, requiring a splenectomy (removal of the spleen), which may increase risk of subsequent infection; or a leak causing infection inside the abdomen, which is a serious complication and may require re-operation. Other complications include stroke, pneumonia, intra-abdominal abscesses, ulcer and pouch problems, reconnection of the pouch and stomach, kidney and liver problems, gallstones, allergic reactions, seizure disorder, and line sepsis.

Initial Here _____

I also understand that additional procedures (for example: removal of the gallbladder, biopsy of the liver, etc, or for any unexpected findings), may be necessary at the time of surgery, which may involve some additional complications (like bile duct injury, bile leak, etc.) requiring additional surgery.

Initial Here _____

I realize that the surgery requires a lifelong commitment, major necessary adjustments in lifestyle and eating habits, supplemental vitamins and minerals, and regular follow-up on my part. I understand that following the surgery, I may not be able to eat certain foods, which I can eat now, and vomiting may occur from time to time, especially if I am not careful about what and how I eat. Blockage of the pouch may require upper Endoscopy (scope) or re-operations. Over stretching of the pouch by overeating may lead to weight gain and staple line disruption, causing the surgery to fail. I also understand that drinking high-calorie liquids, excessive eating, and lack of adequate exercise and physical activities will prevent weight loss or lead to weight gain, even though the surgery may be intact.

Initial Here _____

PT.

MR.#/RM.

DR.

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I consent to receiving blood and I understand there are side effects from this, including but not limited to: HIV, hepatitis, fever, decreased immunity, etc.

Initial Here _____

I recognize that my surgical team for this procedure will normally consist of the surgeon, an anesthesia specialist, an assisting physician or physician assistant, operating room nurses and technicians, and that they may all be assisting with my surgery. In addition and, given that McLaren is a teaching hospital, physician residents, student nurses, and medical students may be observing the procedure as well.

Initial Here _____

I understand that there is no guarantee of weight loss with the surgery, and no guarantee of any sort has been given to me. Re-operations or hospitalizations are always a possibility after this surgery. I understand that after my surgery I must have follow-up care for five years. To assist with this needed follow-up care, I agree to keep my surgeon and the McLaren Bariatric and Metabolic Institute informed of my progress and of any medical problems. I will also inform them of any changes in my address or phone number for five years. I have read and understand this Informed Consent and sign it of my own free will, without any coercion.

Initial Here _____

_____ _____ _____
Signature (Patient) Date Time

_____ _____ _____
Signature (Surgeon) Date Time

PT.

MR.#/RM.

DR.