YOUSIF
Orthopedic Surgery

- o Inpatient
- o Outpatient

Patient's Name:_____DOB:_____

- Please read this form or have someone read it to you
- It's important to understand all parts of this form. If something isn't clear, ask us to explain
- When you sign it, that means you understand the form and give us permission to do this surgery or procedure

I agree for ____**Dr. Yousif**____ along with any assistants* they may choose, to treat the following condition(s): _____
_____shoulder rotator cuff injury/impingement_____

By doing this surgery or procedure on me: _shoulder arthroscopy, rotator cuff debridement/repair, subacromial decompression, acromioplasty, possibly distal clavicle excision_____

*If you'd like a list of the assistants, please ask. We can give that to you.

1. The care provider has explained my condition to me. They have told me how the procedure can help me. They have told me about other ways of treating my condition. I understand the care provider cannot guarantee the result of the procedure. If I don't have this procedure, my other choices are:
   _____No surgery_____
2. The care provider has told me the risks (problems that can happen) of the procedure. I understand there may be unwanted results. The risks that are related to this procedure include: ___Bleeding, infection, nerve, vessel injury, stiffness, persistent pain, need for future surgery, death, risks of anesthesia_____
3. I understand that during the procedure, my care provider may find a condition that we didn't know about before the treatment started. Therefore, I agree that my care provider can perform any other treatment which they think is necessary and available.
4. I understand the care provider may remove tissue, body parts, or materials during this procedure. These materials may be used to help with my diagnosis and treatment. They might also be used for teaching purposes or for research studies that I have separately agreed to participate in. Otherwise they will be disposed of as required by law.
5. My care provider might want a representative from a medical device company to be there during my procedure. I understand that person works for: __ _____

   The ways they might help my care provider during my procedure include:
   - Helping the operating room staff prepare the special device my care provider wants to use
   - Providing information and support to operating room staff regarding the device.
   - Doing other things, including providing hands-on help (describe):___equipment maintenance_____

6. Here are my decisions about receiving blood, blood products, or tissues. I understand my decisions cover the time before, during, and after my procedure, my treatment, and my time in the hospital. After my procedure, if my condition changes a lot, my care provider will talk with me again about receiving blood or blood products. At that time, my care provider might need me to review and sign another consent form, about getting or refusing blood.

   I understand that the blood is from the community blood supply. Volunteers donated the blood. The volunteers were screened for health problems. The blood was examined with very sensitive and accurate tests to look for hepatitis, HIV/AIDS, and other diseases. Before I receive blood, it is tested again to make sure it is the correct type.

My chances of getting a sickness from blood products are small. But no transfusion is 100% safe. I understand that my care provider feels the good I will receive from the blood is greater than the chances of something going wrong. My care provider has answered my questions about blood products.

My decision about blood or blood products	☐ Yes, I agree to receive blood or blood products if my care provider thinks they're needed ☐ No, I do not agree to receive blood or blood products ☐ Not applicable ☐ The following restrictions apply: _____
My decision about tissue implants	☐ Yes, I agree to receive tissue implants if my care provider thinks they're needed ☐ No, I do not agree to receive tissue implants ☐ Not applicable ☐ The following restrictions apply: _____

I understand this form. **My care provider or [his/her] assistants have explained:**	• What I am having done and why I need it • What other choices I can make instead of having this done • The benefits and possible risks (problems) to me of having this done • The benefits and possible risks (problems) to me of receiving transplants, blood, or blood products • There is no guarantee of the results • The care provider may not stay with me the entire time that I am in the operating or procedure room. My provider has explained how this may affect my procedure. My provider has answered my questions about this
I give my permission for this surgery or procedure	_____ My Signature _____ Date _____ Time

Care provider's statement: I have discussed the planned procedure, including the possibility for transfusion of blood products or receipt of tissue as necessary; expected benefits; the possible complications and risks; and possible alternatives and their benefits and risks with the patient or patient's surrogate. In my opinion, the patient or the patient's surrogate understands the proposed procedure, its risks, benefits, and alternatives.

_____ **Care Provider's Signature** _____ **Date** _____ **Time**

_____ **Printed name and title of care provider**

Rotator Cuff Repair

PHASE 1

Week
0-6

Passive range of motion <u>ONLY</u>
Codman/Pendulum exercises

PHASE 2

Week
6-12

Begin **<u>active</u>** range of motion
Discharge sling

PHASE 3

Week
12+

Begin progressive *<u>strengthening</u>* & resistance

PHASE 4

Week
16-20

Starting week **16-20** return to Sport & Work as directed

SLING

- Week 0-4 with activity and sleep
- Week 4-6 with sleep
- Week 6 discharge sling completely