Adjustable Gastric Band Consent Form

NAME:_______________________________________  TODAY’S DATE:____________________________________

I hereby authorize Dr. Umbach to perform an adjustment on my adjustable gastric band. I clearly understand that this involves penetrating the skin over the port, blindly using a special needle for the purpose of instilling or withdrawing fluid from the band around the stomach in order to achieve stomach restriction and weight loss.

I certify that I have been informed that there are significant risks including, but not limited to, bleeding, infection (that may necessitate removal of the port or band with attendant risk of recurrence of morbid obesity), catheter, port and/or band damage that may require prolonged antibiotic treatment, anesthetic risks (including shock/death) cardio-respiratory arrest, damage to the port or catheter (resulting in its removal/replacement), band erosion, fistula formation, damage to nerves, blood vessels, skin, intra-abdominal or thoracic structures including the gastrointestinal system, liver, heart, lungs and pleura, intra-abdominal infection, band slippage, pouch dysfunction, dysphasia, esophageal dilatation or dysfunction, heartburn, gastritis, ulceration, gastric outlet obstruction, reflux esophagitis / inflammation / Barrett’s esophageal cancer, esophageal motility problems, pain, scar, need for open wounds, inability/difficulty eating certain types of food or pills, or a need for additional surgery or procedures. I fully understand the possibility of esophageal dilatation / reflux esophagitis / inflammation / Barrett’s / esophageal cancer / motility problems; over-stretching of the pouch; poor emptying from the pouch; erosion / band slippage / stomach herniation can occur with over-tightening of the band. I recognize that the long-term consequences/risks of this device are unknown. I therefore fully understand that unforeseen conditions may require additional procedures / surgery / investigations for which I will assume full responsibility/financial and otherwise. I further understand that this (adjustable gastric band) requires lifelong medical surveillance and modification of food choices. These include, but are not limited to, the amount and frequency, as well as, a life-long need for nutritional supplementation including, but not limited to, proteins, vitamins, minerals and fluids. I also certify that I have been informed about the alternatives (including non-treatment).

I hereby acknowledge that no warranty or guarantee has been given or implied to me with regard to the outcome. I will refrain from having this device adjusted by anyone other than the health-care providers who are qualified by education, training and experience to handle this device.

I have read and fully understand the above consent, and after carefully considering all the possible risks and consequences and alternatives (including non-treatment), I willingly consent to the above-mentioned procedure.

___________________________________  DATE:  _________________________
Signature of Patient

I, as a witness, have identified the above individual and I have observed his/her signature on this document.

___________________________________  DATE:  _________________________
Signature of Witness

ADJUSTABLE GASTRIC BAND ADJUSTMENT

After obtaining informed consent, under sterile conditions and local anesthesia (with 1% lidocaine without epinephrine), the port was accessed without difficulty / with difficulty using a 1½ / 2¼ / 3½ inch 22g / 20g Huber needle. _____mL was withdrawn under pressure / without pressure and _____mL of normal saline was instilled bringing the TOTAL to _____mL. Its location within the port was confirmed in the usual fashion.

☐ Patient tolerated the procedure well; was able to drink a glass of water without difficulty.

☐ Patient was unable to drink a glass of water, so _____mL was removed bringing the TOTAL to _____mL.

☐ Patient felt no restriction so an additional _____mL was instilled bringing the TOTAL to _____mL.

☐ Patient advised to limit PO intake to liquids for 48 hours.
Mutual Binding Arbitration Agreement

Patient’s Name: ___________________________________

This mutual binding arbitration agreement constitutes an integral part of a contract for medical services by and between Dr. Thomas W. Umbach and Patient (Name): ____________________________ who agree to be bound as described hereunder:

1. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided in Nevada law, and not by lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2. Such arbitration shall be in accordance with the arbitration rules of the Nevada Revised Statutes. This Mutual Binding Arbitration Agreement shall apply to any legal claim or civil action in connection with any and all medical care or medical services rendered, whether inpatient or outpatient, against Dr. Thomas W. Umbach or any of Dr. Thomas W. Umbach’s employees or contracted staff.

3. The execution of this Mutual Binding Arbitration Agreement shall not be a precondition of the furnishing of medical services by Dr. Thomas W. Umbach. This Mutual Binding Arbitration Agreement may be rescinded by written notice from the Patient or Patient’s legal representative within 30 days of signature.

4. The Mutual Binding Arbitration Agreement shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Date: ___________________________ Time: ____________________ A.M./P.M.

Signature: ___________________________________________________________

If signed by other than patient, indicate relationship:

.patient □ parent □ legal guardian □ legal representative

MBAA 2011.02.A