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## Dr Russell D. Govender

### Orthopaedic Spinal Surgeon

MB BCh (Wits), FC Orth (SA), AOSpine Fellowship

Practice Number: 028 000 0588288  
HPCSA: MP0617024

I, the undersigned \_\_\_\_\_ (Full names), hereby give my  
consent for the performance of the following procedure by Dr Russell Govender

1. My surgeon has provided me with a general explanation of the nature of this operation / procedure and the reasons for its indication for my particular medical condition.
2. My surgeon has also discussed with me the risks and benefits of the operation/procedure/treatment/process. Some of these risks include, but are not limited to, the following  
**General surgical complications: infection, wound breakdown, haematoma, DVT, blood loss requiring transfusion, prolonged hospitalization, death.**
3. My surgeon has also explained that I can have the following possible consequences and complications as a natural result of undergoing the operation:  
**Specific complications: nerve root injury, paralysis, epidural haematoma, arachnoiditis, vascular injury, dural tears and CSF leaks, failure of relief of symptoms, iatrogenic instability, wrong level surgery, instrumentation failure and malposition, non-union, recurrence of symptoms.**
4. My surgeon has explained alternative options to undergoing this operation.
5. My surgeon has explained that alternative operative measures may be deemed necessary or desirable during the course of this operation/treatment/process, also inclusive of:  
**Unplanned fusion with or without instrumentation due to iatrogenic instability, reoperation due to unforeseen complications arising from surgery.**
6. My surgeon has also explained to me that other physicians and health care providers may participate in my care.
7. I acknowledge that images from my investigations and scans as well as operative images may be used by my physician for research purposes and presentation and that my privacy will be protected in this regard.
8. After discussing all of the above, my physician gave me an opportunity to ask questions and seek further information regarding to above items. I believe that I do not require further information at this time, and I am prepared to proceed with the recommended operation/treatment/procedure/ process.
9. I understand that I can revoke this consent at any time up until the time the operation/treatment/procedure/process is started.
10. I acknowledge that I/the patient has been informed of all the above in a language understood by me/the patient

SIGNED AT..... THIS THE ..... DAY OF ..... 20.....

SIGNATURE OF PATIENT.....  
Signature of patient/parent/spouse/guardian

WITNESS 1 ..... WITNESS 2 .....