Catholic Health System

CONSENT TO SURGERY AND/ OR PROCEDURE AND ANESTHESIA - MSMH

Patient Identification Information

1. I,_____, hereby authorize Dr._____and/or whomever he/she designates to assist him/her to perform upon the above named person or me the following surgical operations and/or procedures:

   (Describe in medical terms):_____

   _____

   _____

   (Describe in lay terms):_____

   _____

   _____

2. The above named provider has fully explained to me the nature and purposes of the operation/procedure, has informed me whether any provider, other than him/herself, will be performing important tasks related to this operation/procedure, and has also informed me of expected benefits, the likelihood of achieving goal, possible complications, discomforts and risks that may arise, as well as alternatives to the proposed treatment and the risks and consequences of no treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction.

3. I understand that during the course of the operation or procedure unforeseen conditions may arise which require operations or procedures different from those described. I consent to the performance of those additional operations or procedures. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the operation or procedure.

4. I understand that any tissue or parts surgically removed shall be disposed of by the hospital in accordance with its customary practice.

5. If I am to receive the implantation of an equipment/device, I consent to the disclosure of my Social Security number to the manufacturer for the purposes of tracking the equipment/device in accordance with the Safe Medical Device act regulation.

6. For the purpose of advancing medical knowledge, I consent to the admittance of medical students, technical specialists or observers in accordance with the ordinary practice of the above noted Hospital, Catholic Health System. I consent to the use of closed-circuit television, taking of photographs (including videos), and the preparation of drawings and similar illustrative graphic material for scientific purposes providing my identity is not revealed. I understand that any de-identified photos or video taken during my procedure for education/training purposes will not be maintained as part of my medical record and are solely the property of the hospital.

7. At the discretion of my surgeon, I consent to the presence of a manufacturer's representative to observe during the procedure, but that such representatives will not be involved directly or indirectly in the operation/procedure.

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8. ANESTHESIA

I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for anesthesia. The anesthesia team may consist of Anesthesiologists, Residents and Nurse Anesthetists. Advanced Emergency Medical Technicians may also participate in my care under the supervision of the Anesthesiologist.

I realize that there is the possibility of unavoidable damage to teeth during surgery and anesthesia, particularly if teeth are weak, loose, decayed, baby teeth, or artificial.

9. DNR ORDERS ☐ Not applicable

I have been advised and understand it is the Facility's policy that Do Not Resuscitate (DNR) orders shall be suspended and not honored during this operation(s)/procedure(s). However, I have been further advised that it is my right to direct that a DNR Order be honored during this operations)/procedure(s). Check appropriate box below, if applicable:

☐ I want the **DNR Order to be honored** throughout the operation(s)/procedure(s)

☐ I want the **DNR Order suspended and *not* honored** during the operation(s)/procedure(s)

10. BLOOD TRANSFUSION ☐ Not applicable

Blood is essential for the body to function. Care is taken to limit a patient's loss of blood and thus reduce the need for a transfusion. However, if the blood count falls too low, the patient may go into shock or coma and/or suffer serious harm or even death. If a low blood count poses a threat to you in your course of treatment, there may be no effective alternative to transfusion. I have been fully informed that no transfusion is 100% safe, however, present testing methods make the risks very small. Risks do include, HIV infection, Hepatitis B, Hepatitis C, other infection as well as fever, itching, or transfusion of incorrect blood type which is highly unlikely but can be fatal.

I have discussed possible alternatives with my care provider, including no transfusion, autologous transfusion (donation of my own blood), and designated/directed donor transfusion (collection of blood from donors selected by me). I understand that all these alternatives may not be available due to timing or health reasons, and that the above risks may still apply.

☐ I consent to the transfusion of blood or blood components that may be necessary relative to the procedure whether before, during, or after the procedure.

☐ I refuse the transfusion of blood or blood components

My signature confirms that the procedure _____

_____

with its associated risks and benefits has been explained to me, understood and accepted.

PATIENT/RELATIVE/ HEALTH CARE PROXY OR GUARDIAN:

_____ _____ _____
(Signature) (Date) (Time)

_____
(Relationship, if not patient)

WITNESS TO SIGNATURE:

_____ _____ _____
(Signature) (Date) (Time)

Provider's Certification: I certify that either a designated provider or I have (1) reviewed and approved the name of the procedure and the description listed hereto; and (2) have explained the procedure to the patient/patient's representative named above in manner to permit the patient to make a knowledgeable decision of the reasonable risks and benefits involved in this procedure.

_____ _____ _____
(Provider's Signature) (Date) (Time)

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