UNIVERSITY MEDICAL CENTER

CONSENT #2

Informed Consent to Operate or Other Special Procedures

AFFIX PATIENT INFO LABEL HERE

Patient Name ______________________ MR# __________

Please Note: You have been given information about your condition and the recommended surgical, medical or diagnostic procedure(s) to be used. This consent form is designed to provide written confirmation of such discussion by recording some of the more significant medical information given to you. State law requires that informed consent be obtained. BEFORE SIGNING THIS FORM, all items must be addressed with you, and you may cross out and initial any statements that do not apply.

Date of Consent: ____________________ Patient's Full Name: ______________________________

1. I authorize (Practitioner) ______________________________ (MD, DO, PA, APN) and his/her authorized residents and assistants to treat the condition or conditions which are indicated by the examinations and studies already performed. *(Practitioner: Explain the nature of the condition and the need to treat such condition in layman's terms)*

   ____

   ____

   ____

2. The procedure/operation necessary to treat my condition, as explained to me by (Practitioner)

   ____ (MD, DO, PA. APN) is

   ____

   (Practitioner: Write description of procedure in layman's terms)

   ____

3. Additional materials given ❑ No ❑ Yes ________ Copy attached

4. The nature and purpose of the above procedure/operation, as well as its possible disadvantages, consequences, alternatives, risks, problems related to recuperation and risks of not receiving care have been reasonably explained to me, and no guarantee or assurance has been made as to the results which may be obtained, recognizing that neither medicine nor surgery is an exact science.

5. I understand that during the course of the procedure/operation, unforeseen conditions may become apparent, which requires an extension or modification of the original procedure/operation from that described above and I authorize that these may also be performed.

6. I consent to the administration of anesthesia by a physician anesthesiologist and his/her authorized resident or a credentialed physician in the case of conscious sedation, as he/she may deem necessary or advisable in the performance of the procedure.

7. I further consent to the disposal by hospital authorities of any tissues, fluids or parts which may be removed during this authorized operation/procedure.

8. For the purpose of medical education, I consent to the possible photographing, televising and/or video taping of the procedure to be performed, providing no identifying data is included. I waive my right to inspect and/or approve the finished product and its specific use.

9. I acknowledge that the risks, benefits and alternatives to transfusion and the possible transfusion of blood products were discussed with me.

   I consent to the use of blood products YES NO (circle one)

10. With regard to Advanced Directive and identification of a Healthcare Representative:

    I have an Advanced Directive (Living Will) YES NO (circle one)

    A copy of the Advanced Directive is on the chart YES NO (circle one)

    I have discussed my wishes with my Physician (practitioner) and that discussion is documented below:

    ____

    ____

    I have selected a Healthcare Representative YES NO (circle one)

    If yes, name of Healthcare Representative: ______________________________.

    Relationship of Healthcare Representative: ______________________________.

11. **CONSENT:** I have been given sufficient opportunity to ask questions about my condition, risks of not receiving treatment, alternative treatments, risks of treatment, the procedures to be used, and the risk and hazards involved and problems related to recuperation. All of my questions have been answered to my satisfaction and I have sufficient information to give this informed consent. I hereby consent to the above described procedure with the understanding that this consent can be withdrawn by me at any time prior to the procedure.

    I certify that this form has been fully explained to me and that I have read it, or have had it read to me, that the blank spaces have been filled in and that I understand its contents.

_______________________________ *Signature of Patient and Date or(Legal Guardian, Healthcare Representative or Next of Kin)*

_______________________________ *Witness Signature and Date*

_______________________________ *Print Name and Relationship, if other than Patient*

_______________________________ *Print Witness Name*

Certification of Practitioner

I hereby certify that I have discussed the contents of the consent form with _______________ and answered any questions, and in my opinion he/she fully understands what he/she has been told.

_______________________________ Practitioner's Signature / Date

_______________________________ Surgery Date

Certification of Attending Surgeon:

I hereby certify that I have determined, based on x-rays, tests and/or examination that

(insert patient's name) _______________________________'s site of operation is

RIGHT LEFT BILATERAL NON-APPLICABLE

MULTIPLE STRUCTURES (Fingers, toes, lesions) LEVEL (spine – neck, upper back, lower back)

Attending Surgeon's Signature / Date _______________________________

THIS SECTION IS TO BE COMPLETED ONLY FOR PATIENTS WHO HAVE A CURRENT DO NOT RESUSCITATE (DNR) ORDER ON THE CHART

Please have the patient initial the appropriate statement:

__________ I have discussed the provisions of my request not to be resuscitated with my physician, and understand that my request will be suspended during the procedure/surgery and a 48-hour post procedure/operative period.

__________ I have discussed the provision of my request not to be resuscitated with my physician and I wish the DNR order to be in effect during the procedure/surgery.

_______________________________ *Patient (Legal Guardian, Healthcare Representative or Next of Kin) / Date*

I am aware of the patient's request in regard to the above DNR order.

_______________________________ *Practitioner's Signature / Date*

_______________________________ *Anesthesiologist's Signature / Date*