UNIVERSITY MEDICAL CENTER

CONSENT #2

Physician's Special Consent for Breast Tumor Surgery

Please Note: 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 paragraphs that do not apply.

Date: _____ Time: _____ Place: _____

Patient's Full Name: _____

1. I, _____, understand that I am to undergo surgery for a lump in a breast.

   I hereby authorize Dr.(s)_____ with his/her authorized residents and assistants to perform upon the above-named patient, the following operation. *(Check One)*:

☐ BIOPSY ONLY (Excision of Mass, Partial Mastectomy)

I hereby consent to have a biopsy of a lump in my breast performed. However, I do not consent to have any other surgical procedure performed in conjunction with the biopsy. I understand that if the biopsy reveals the tumor to be malignant, further surgery may be indicated. I also understand that this may require my undergoing administration of anesthesia for a second time with the risks attendant thereto.

Procedure: _____

_____

☐ REMOVAL OF BREAST OR OTHER OPERATION

I hereby consent to have an operation to remove my breast, if it is determined that the breast has a malignant tumor. I also understand that at the time of my surgery, it may be discovered that some other operation is necessary to properly treat my breast abnormality and I hereby consent to such treatment and operations as deemed necessary by the surgeon.

Procedure: _____

_____

☐ BIOPSY, REMOVAL OF BREAST AND OTHER NECESSARY OPERATIONS

I hereby consent to a biopsy to determine the nature of my breast abnormality. Should it be determined that I have a malignancy or other abnormality, which requires additional surgery, I give further consent to such operation(s), including, but not limited to the removal of my breast during the same procedure. I recognize that the decision to perform such further operation shall be at the discretion of my surgeon and other physicians he/she shall deem it appropriate to consult, and that I shall not be awakened from anesthesia to participate in these decisions.

Procedure: _____

_____

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

_____

Patients Initials

3. The nature and purpose of the above procedure, as well as its possible disadvantages, consequences, alternatives and risks 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.

4. 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.

5. I further consent to the disposal by the hospital authorities, of any tissue or parts which may be removed during surgery.

6. For the purpose of medical education, I consent to the possible photographing, televising and/or videotaping 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.

7. 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)*

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

   I have an Advance Directive (Living Will) Yes No *(circle one)*

   I have selected a Healthcare Representative Yes No *(circle one)*
   If yes, name of Healthcare Representative and relationship: _____
   Physician Progress Notes: _____
   _____
   _____
   _____ Patient Initials: _____

9. I acknowledge that I have read and agree to the foregoing, that the proposed operation or procedure(s) have been satisfactorily explained to me and that I have all the information that I desire, therefore I hereby give my authorization and consent.

_____ _____
Witness to Signature Patient Healthcare Representative or Next of Kin

_____ _____
Print Witness Name Relationship

Certification of Physician

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

_____ _____
Physician's Signature Date

Certification of Attending Surgeon:

I hereby certify that I have determined, based on x-rays, tests and examination, that *(insert patient's name)*_____ site of operation is *(circle one)* Right, Left, Bilateral, or Non-Applicable

_____ _____
Attending Surgeon's Signature Date