HSHS St. John's Hospital

CONSENT FOR PERFORMANCE OF OPERATION OR OTHER PROCEDURE AND/OR ADMINISTRATION OF SEDATION/ANESTHESIA

ALL ITEMS MUST BE COMPLETED

Part A: Consent for operation/procedure

1. I hereby authorize and consent to the performance upon me *(or) (name of patient)*_____
   of the following operation or procedure:_____
   _____
   (Specify portion of body with designation right or left where applicable)
   by Dr._____and his/her assistants, Residents and Fellows and to
   (physician responsible who is not a hospital employee)
   ministrations and medical procedure incidental to said operation or procedure by said physician and by assistants, technicians, nurses, and other personnel designated or approved by himself / herself.
2. The nature and purpose of the operation or procedure, alternative methods of treatment, risks involved, possible complications, as well as possible results of not having this procedure have been explained to me by
   Dr._____and I understand this explanation.
   (physician responsible)
   I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure. It has been explained to me that certain risks, including death, severe loss of blood, infection, cardiac arrest, limited physical ability, disfigurement, and serious unknown consequences can result from any operation.
3. I further consent to the performance of any other operation or procedure, preceding, during or following the above mentioned procedure which the physician in charge deems necessary or desirable to be performed by himself/herself or his/her designees in the exercise of professional judgement. This authority shall extend to treating all conditions that require treatment, in order to preserve life or to prevent further injury or complication which are not known to the physician in charge at the time the operation is commenced.
4. **Do Not resuscitate (DNR) Policy:**I understand that by signing this consent I am also consenting to a temporary suspension of any prior Do Not Resuscitate (DNR)orders or instructions and advance directives while I am under the direct care of anesthesia providers and until I am discharged from the post anesthesia care unit. I have discussed the temporary suspension of any prior DNR orders or instructions with my provider. If I do not agree to this temporary suspension of DNR status, I may maintain any prior DNR orders and instructions, and I understand that it is my responsibility to discuss this with my anesthesia provider prior to the administration of any anesthesia medication or agents.
5. I consent to the use of any equipment or instrumentation deemed necessary, advisable, or helpful by my physicians. Said equipment or instrumentation includes, but is not limited to, such devices as the cell saver, ultrasonic aspirator, lasers, tourniquets, hypothermia/hyperthermia machines, cautery, drills, etc.
6. I consent to the administration of blood or blood components. I understand this involves the risk of viral hepatitis, AIDS, or other reaction, and agree that no assurance against hepatitis, AIDS, or other adverse reaction has been given to me by the hospital, its employees, its Transfusion Service or any person whatsoever as to blood or blood components so administered or upon the transfusion thereof.
7. I further consent to the disposal by the hospital of any tissues or parts which it may be necessary to remove from my said or said patient's person or body during any of the above mentioned operations or procedures.
8. I also consent to the preservation of such tissue or parts by the hospital for scientific or teaching purposes.
9. I also consent to the preservation of such tissue or parts by the hospital for use in grafts upon living persons.
10. I am aware that sterility may result from this operation. I know that a sterile person is incapable of conceiving.
11. If my physician during performance of the operation/procedure on me so requests, I further consent to photographs or motion pictures of my (or said) patient's body or organs being taken during the course of any said operation or procedure, if the purpose of the same is for the advancement of medical or surgical knowledge, and also I consent to the use of such photographs or motion pictures for such purpose.
12. **I understand that <u>all physicians, physician assistants,</u> and <u>Advanced Practice Nurses (APNs)</u> providing my care including, but not limited to, my treating physician, hospital−based physicians, radiologists, pathologists, anesthesiologists, neonataoligists and Emergency Department physicians are <u>not employees or agents</u> of the hospital, but rather are independent contractors who have been granted the privilege using its facilities for the care and treatment of the patients.**

Notation of other documentation or additional comments:_____

continued

_____ _____ _____

Signature of patient *Date* *Time*

_____ _____ _____

Signature of witness to signature of patient or authorized person *Date* *Time*

_____ _____

Reason patient unable to sign *Signature and relationship of person authorized to consent for patient*

The above procedure, alternatives, attendant risk, and consequences of the procedure explained to the patient on

Date_____Time_____ _____

Signature of physician

Part B: Consent for sedation/anesthesia – ☐ Does not apply (check if no sedation or anesthesia is planned)

1. Sedation (may be administered by procedural physician or anesthesiologist): I authorize the administration of sedative agents for my procedure as may be considered necessary or desirable in the judgement of my physician, Residents, Fellows or anesthesiologist. I understand the purpose is to create a depressed level of consciousness and reduced anxiety. Depending upon the medication used, it may produce amnesia. I understand that the administration of sedation has certain foreseeable and non−foreseeable risks and consequences which may include, but are not limited to the following: changes in blood pressure, drug reaction, and respiratory depression. I may require assistance to maintain an open airway. Sedation options have been explained to me.

2. Anesthesia (administered by a member of the anesthesia care team): I consent to the administration of general anesthesia and/or anesthetic agents for my operation, procedure or obstetrical delivery as may be considered necessary or desirable in the judgement of the physician in charge of my anesthesia.

   I understand that the administration of any type of anesthesia has certain foreseeable and non−foreseeable risks and consequences which may include, but are not limited to the following: injury to my mouth, teeth, bridge work, and dentures during airway management, sore throat, hoarseness, nausea and vomiting, muscle soreness, injury to eyes, changes in blood pressure, drug reactions, cardiac arrest, brain damage, paralysis or death. I also understand some of the medications administered to me can interfere with the effectiveness of my birth control pills for up to 7 days following my surgery.
   I further understand that my anesthesia care will be provided by or under the supervision of an anesthesiologist who is an independant practitioner and who is a member of the St.John's Hospital medical staff but not an employee of St. John's Hospital.
   I understand that the lengthy use of general anesthetic and sedation drugs during surgeries or procedures in children younger than three years or in pregnant women may affect the development of the chiildren's brains.

3. I further consent to the administration of additional alternative sedative or anesthetic agents, preceding, during or following the above mentioned procedure which the physician in charge deems necessary to be performed by himself/herself, Residents, Fellows or his designees in the exercise of professional judgement. This authority shall extend to sedative or anesthetic agents which are not planned at the time the operation is commenced.

Notation of other documentation or additional comments: _____

_____ _____ _____

Signature of patient *Date* *Time*

_____ _____ _____

Signature of witness to signature of patient or authorized person *Date* *Time*

_____

Reason patient unable to sign *Signature and relationship of person authorized to consent for patient*

The above procedure, alternatives, attendant risk, and consequences of the anesthesia/sedation were explained to the patient on

Date_____Time_____ _____

Signature of anesthesiologist/physician administering the anesthesia/sedation

Translators Statement

I have translated the contents of this form into _____for the benefit of the patient who
(Name of Language)
understands this language better than English. To the best of my ability, I believe the patient understands, as witnessed by his/her signature on the Consent Form.

_____ _____ _____ _____

Date Time Signature of Translator Translator Identification Number