Hospital Sisters
HEALTH SYSTEM

INFORMED CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

I understand that I have the option to disagree with any statement below. To indicate that I will draw a line through the words, write the word "no" and the date, time, along with my initials.

1. I agree to have_____("Physician/Practitioner")and any Associates or Assistants
(Physician/Practitioner first/last name)
selected by the Physician/Practitioner perform the following operation(s) or procedure(s) (The "Procedure") on me or the patient named above:

_____

_____

_____

2. I consent to the administration of such sedation/anesthetics as are necessary or appropriate for the Procedure. If procedural sedation is administered, I understand it is *given* to keep me comfortable during the Procedure. A nurse or other qualified personnel will administer the procedural sedation. I understand that amnesia of variable duration is a probable and often desirable consequence of sedation/anesthesia, however amnesia cannot be guaranteed. I understand that possible complications of sedation/anesthesia may include difficulty breathing, low blood oxygen levels, low or high blood pressure, heart rhythm disturbance, prolonged sedation or allergic reaction. I have been fully informed of the risks and possible complications of procedural sedation, and/or anesthesia, and have been given the opportunity to ask questions.

3. I agree to have additional procedures performed on me during the Procedure if my Physician/Practitioner decides they are needed or appropriate for reasons not known before the Procedure.

4. I also authorize my Physician/Practitioner to provide or arrange for the provision of additional services during the Procedure, as necessary or advisable by my Physician/Practitioner, including but not limited to, pathology, radiology, diagnostic and therapeutic services.

5. Administration of Blood and/or Blood Products: I consent to the administration of blood and/or blood products during my **surgery and post-surgery** hospitalization **if deemed necessary** even if not anticipated, to be administered as determined by my physician. I have been informed of and understand the risks, benefits, and alternatives to the administration of blood and/or blood products.

_____I **Do NOT** consent to the administration of blood and/or blood products
(Initials)

6. If I have requested not to be resuscitated, I understand that this decision may require a discussion between me and the physician(s) responsible for my care. At my or my legal representative's request, a Do Not Resuscitate order may remain in effect during the diagnostic or therapeutic procedure.

7. All procedures have risks, including bleeding, infection, serious injury and even death. I have been informed of the nature of the Procedure, the potential benefits, side effects and risks (including those identified above and the following specific risks, if applicable, _____

_____
(if none leave blank or specify risks)

of the Procedure, and problems that may occur during recovery. I have also been informed of the reasonable alternatives to the Procedure (including the possibility of not performing the Procedure) and the risks and benefits of such alternatives and the likelihood of achieving my goals. If applicable, my Physician/Practitioner has discussed the implant planned and implant type to be used. I understand that the explanations I have received may not be exhaustive or all-inclusive and that other more remote risks may be involved. However, I agree that the information that I have received is sufficient for me to consent to the Procedure.

8. Surgical Assistant Services: My Procedure may require the services of a Surgical Assistant as requested by my Physician/Practitioner. If I have any questions regarding the services or procedures to be performed by the Surgical Assistant, I will ask my Physician/Practitioner to discuss this with me prior to the Procedure. I understand the Surgical Assistant will only perform tasks for which they are qualified and authorized.
9. My Procedure will be completed by a team of medical professionals that may include additional practitioners other than the operating practitioner, including, but not limited to, other physicians, residents, advanced practice providers, and medical and other applicable students (such as nurse practitioner and physician assistant students), who may be performing important tasks related to the surgery, or examinations or invasive procedures for education and training purposes, in accordance with hospital policies. Important surgical tasks may include, but are not limited to: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines.
10. An additional informed consent will be obtained for examinations or invasive procedures conducted under anesthesia solely for educational and training purposes. These examinations or procedure may include, but are not limited to, breast, pelvic, prostate, and rectal examinations, as well as others specified under state law.
11. I consent to the presence of an observer(s) in the procedure room when deemed appropriate by the Physician/Practitioner.
12. I hereby authorize the hospital to keep, use or dispose of anything removed during the Procedure including but not limited to, any tissues, organs, bones, bodily fluids, medical devices or other specimens.
13. **Photographing or Videotaping:** I consent to the photographing or videotaping of the Procedure, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying them. I also consent to the photographing or videotaping of the Procedure for purposes of my Physician/Practitioner making them available to me or as authorized by me.
14. I understand that telemedicine services may be used as part of my care and if so, this will be explained at the time of service. I understand that telemedicine includes the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications. Telemedicine services have risks, including but not limited, poor resolution of transmitted data such as images, delays in treatment and evaluation due to equipment failure, unauthorized access by third parties during data transmission, and the inability of the physician to physically exam me. I understand I will be informed of the nature of the telemedicine visit, the potential benefits, and risks (including those identified above) of the visit.

Signatures:

By signing below, I indicate that I have read and understand this consent form. I have the right to consent to or to refuse any proposed operation or procedure at any time prior to its performance. I am aware that the practice of medicine and surgery is not an exact science, and no guarantee has been made as to the results of the Procedure or any cure. I have had a full opportunity to ask questions concerning my condition, the Procedure, the risks, and the alternatives. The questions that I have asked have been answered to my satisfaction. I give permission for the items above, except those I drew a line through, dated, timed, and signed.

Signature of Patient	Date	Time	Signature of Witness

Complete below if the patient is unable to sign or is a minor:

If patient unable to sign, state reason: _____

Signature of Legal Representative	Date	Time	Signature of Witness

Print Name of Legal Representative	Relationship to Patient

(Optional - the performing Physician/Practitioner may sign the statement below that the informed consent discussion has taken place. If not, documentation must be included in the patient's medical record to that effect.)

PERFORMING PHYSICIAN/PRACTITIONER STATEMENT OF INFORMED CONSENT:

I have discussed with the patient or the patient's legal representative the risk of complications, the side effects, the potential benefits of performing the planned Procedure, the likelihood of success, potential problems related to recovery from the procedure, and any appropriate alternative options (including the option of not performing the procedure) associated with the planned Procedure, including the risks and benefits of such alternatives, and answered any questions that the patient may have had regarding the planned Procedure.

Signature of Performing Physician/Practitioner	Date	Time