[FACILITY NAME & LOGO)

Patient Name _____ MRN _____

Date _____

Consent for Surgery/Procedure

- Please **read** the form.
- **Ask** about any part you do not understand.
- **Do not** sign this form until **all** your questions have been answered.
- When you **sign**, you are giving us permission to do this surgery or procedure.

I, _____ (patient's name) permit Dr. _____ along with any assistants the doctor may choose, to do this surgery or procedure on me at ***[name of facility]:***

_____

_____

Name of surgery or name of procedure in medical words

Mark one:

☐ **Left side** ☐ **Both sides** ☐ **Right side** ☐ **Does NOT apply**

Benefits of this Procedure:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

Modify to add benefits, risks and alternatives of the procedure that are unique to the patient and the procedure.

-
-
-

General Risks of Procedures:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

Modify to general risk of procedure if more accurate & modify risks to for the procedure

- Small areas of the lung may collapse. This would increase the risk of infection. This may need antibiotics and breathing treatments.
- Clots may form in the legs, with pain and swelling. These are caked DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go into the lungs. This can be fatal.
- A strain on the heart or a stroke may occur.
- Bleeding may occur. If bleeding is excessive, you may need a transfusion.
- Reaction to the anesthetic may occur. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you. **Insert type of anesthesia if know.**

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Risks of this Procedure:

Identify both the risk and the consequences.

Example: Bleeding. This may require transfusion. Consider adding method to assist in comparing risks (ratio, bar graph, compared to everyday risk).

-
-

Risks Associated with Smoking:

Smoking is linked to an increased risk of infection. It can also lead to heart and lung complications and clot formation.

Risks Associated with Obesity:

Obesity is linked to an increased risk of infection. It can also lead to heart and lung complications and clot formation.

Risks Specific to You:

_____

_____

Alternative Treatments:

Other choices:

-
-
- Do nothing. You can decide not to have the procedure.

If you choose not to have this treatment:

Identify the likely outcomes and the consequences

Example: The appendix may rupture. This would require emergency surgery.

-
-

(Doctor or health care worker fills out the information above)

_____

Name of surgery or name of procedure in *patient's own words*

[FACILITY NAME & LOGO)

Patient Name _____ MRN _____

Date _____

Teach Back:

___ **Reason(s) for the treatment/procedure:** _____
___ **Area(s) of the body that will be affected:** _____
___ **Benefits(s) of the procedure:** _____
___ **Risk(s) of the procedure:** _____
___ **Alternative(s) to the procedure:** _____

OR

Patient elects not to proceed: _____ **Date:** _____ **Time:** _____
Patient Signature

Validated/Witness: _____ **Date:** _____ **Time:** _____

(What the patient or family says back to the doctor or health care worker – quote the patient or family **Above**)

I understand and my doctor has told me:

- What I am having done and why I need it.
- The possible risks to me of having this done.
- What might happen to me if I don't have it done.
- What other choices I can make instead of having this done.
- What can happen to me if I choose to do something else.
- What can happen to me if I choose no treatment.
- That there is no guarantee of the results.

1. I understand that my doctor may find other medical conditions he/she did not expect during my surgery or procedure. I agree that my doctor may do any extra treatments or procedures he/she thinks are needed for medical reasons during my surgery or procedure.
2. I understand that **if my doctor thinks I need blood** for medical reasons, **it will be given.**
3. I understand someone may watch or help with my surgery or procedure for medical teaching. These people are usually medical or nursing students. A technical advisor may be in the operating room as needed. My doctor will supervise them.
4. I understand the doctor may remove tissue or body parts during this surgery or procedure. If it is not used for lab studies or teaching, it will be disposed of, as the law requires.
5. I understand pictures or video of my surgery or procedure may be taken for teaching purposes and/or to document my procedure. My identity will be protected.
6. If I receive a medical device, I permit [NAME OF FACILIT] to use my information to help the manufacturer locate me if there is a need.
7. I have told my medical history to my physician(s) and/or his/her assistant(s).

[FACILITY NAME & LOGO)

Patient Name

MRN

Date

I have had all my questions answered.

Nurse to alert physician if the patient has a Do Not Resuscitate order on the chart to review this decision with the patient.

Patient Signature: **Date:** **Time:**

Patient unable to sign because:

Signature of Patient's legal Representative And Relationship to patient: **Date:** **Time:**

Witness: **Date:** **Time:**

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature **ID#** **Date:** **Time:**

I have reviewed this consent form. The patient has consented to the procedure I have planned. I have discussed with the patient/surrogate decision-maker the risks, benefits, alternatives, and potential complications for the planned procedure. The patient explained what he/she has understood from our discussion and wishes to proceed.

Physician Signature: **Date:** **Time:**