UNITY HEALTH SYSTEM/PARK RIDGE HOSPITAL

Consent for Surgical Procedure Or Invasive Procedure

I authorize Dr. ______________________ and his/ her assistants to perform upon ______________________
the following procedure: ____
In addition, Dr. ______________________ and his/ her assistants are expected to perform the following procedure:
____

The nature and purpose of the procedure, the risks involved, and the possibility of complications have been fully explained to me, as well as the possible alternative methods of treatment and the risks related to the alternative treatment, including the risks of no treatment. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from the procedure. I acknowledge that I was given the opportunity to ask questions during the course of all explanations as described above and that I have received satisfactory answers to my questions.

I acknowledge that certain conditions may be revealed to the physician involved at the time of the procedure which were not recognized before and which may call for procedures and/or assistants in addition to those originally contemplated; I authorize the performance of such procedures in accordance with the judgment of the operating surgeon or physician involved.

I consent to the suspension of my DNR status from start of anesthesia to discharge from the Post Anesthesia Care Unit.

I consent to the administration of anesthesia, moderate sedation or deep sedation by a physician, and the use of such anesthesia agents/modalities as deemed advisable. In the event moderate sedation is administered by the undersigned physician/practitioner, the risks/benefits have been explained to me.

The merits and risks of the use of blood and blood products, the consequences of the refusal to use blood and blood products, and the available alternatives to the use of blood and blood products, including self donation, and use of a designated donor have been fully explained to me. I consent to the use of blood or blood products if deemed necessary by the physicians involved in my care.

I consent to photographing, videotaping or medical illustrating of the procedure or tissues removed, for medical, scientific, or educational purposes, provided my identity is not revealed. I have the right to request cessation of recording or filming. I have the right to rescind consent for use up until a reasonable time before the recording or film is used.

I consent to the presence of medical equipment company representatives in the operating room and to their provision of technical support to the operating physician involved in the procedure; in no event does this consent permit performance of a procedure by such representatives.

I consent to the disposal of any tissue or body parts removed in the course of the operation by hospital authorities/ designee.

I certify that I have read and fully understand the above consent after adequate explanations were made to me, after all blanks were filled in, and inapplicable paragraphs, if any, were crossed out. Specific exceptions to this consent are listed below:

____

Patient Signature: ______________________ Relationship: ______________________
Parent/ Guardian Signature: ______________________ Other ______________________

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.

I have discussed the procedure including the potential risks, benefits and alternatives with the patient/ guardian and have answered all questions posed.

Physician/ practitioner ______________________ Date: ______________ Time: __________
(Signature)

Patient Name:______________________________

Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery

	Diagnosis	Operation/ Procedure	Verification Components	Signature
Pre An/ Pre-procedure			□ Patient and procedure verified □ Site Marked If site not marked, reason □ Midline incision □ Single organ or body part □ Contra-lateral part/ organ absent □ Patient refused	______________ Surgeon/ proceduralist ______________ Circulating nurse/ licensed staff
"Time Out" Pre-incision or Pre-procedure			□ Yes, verifying correct patient, procedure, site □ Correct patient position	______________ Circulating nurse/ licensed staff Date: Time:

□ Surgeon/ anesthesiologist/ proceduralist has signed History and Physical with appropriate update on day of procedure.

Other major invasive procedures, which require informed consent but not limited to cardiac catheterization, GI procedures, paracentesis, thoracentesis, lumbar puncture, chest tube insertion, arthrocentesis, bone marrow biopsy, etc. and are performed in areas other than the operating room, also require verification of patient, site and procedure. This information must be documented on this form, on the Invasive Procedure Documentation form, or alternate forms developed by individual departments for this purpose.

If a different form is used to address the protocol outlined above, please indicate which form.

□ See Invasive Procedure Documentation Form

□ Alternate form used:______________________________
(*Form title*)