Consent to Surgical/Invasive Procedure

1. **AUTHORIZATION:** I authorize the performance on myself/the patient, __________________________________________, the following surgical/invasive procedure(s): ____________________________________________________________

I understand that the surgery/procedure will be performed under the direction, supervision and authority of the following physicians or medical practitioners or their associates:

2. **SEDATION:** I have been advised that moderate sedation may be administered to perform the procedure and have been informed of the risks, benefits and alternatives. The risks or complications include but are not limited to nausea, vomiting, memory dysfunction/memory loss, depressed breathing, injury to blood vessels, increased awareness, anxiety or discomfort, and potential conversion to general anesthesia.

3. **OTHER QUALIFIED PRACTITIONERS:** I have been advised that the surgery/procedure(s) may be performed by other medical practitioners under the direct or indirect supervision of my/patient’s physician/provider or associate. I understand that the qualified practitioners may include but are not limited to, residents, medical students, other clinical students, allied health professionals or assistants. I consent to these other qualified practitioners to perform important parts of the surgery/procedure(s) and I understand that they will only be performing those tasks within their individual skills/training.

4. **TECHNICAL ASSISTANCE:** I understand that physician/provider or associate may utilize the technical support of a vendor representative related to the use of medical device, procedural equipment or instrumentation.

5. **OBSERVATION:** I consent to the admittance of qualified observers for approved educational purposes as approved by the Advocate facility and the Attending Provider.

6. **NATURE OF PROCEDURE:** I have had an opportunity to discuss the surgery/procedure with my/the patient’s physician/provider or associate. The nature of my condition, the nature and purpose of the surgery/procedure, including the failure to treat my condition, the risks and benefits, possible complications and adverse outcomes (including but not limited to severe disability or death) and any available, feasible treatment alternatives have been explained to me. I do hereby assume all risks involved and understand that no guarantee or assurance has been given to me by anyone as to the results that may be obtained.

7. **ADDITIONAL PROCEDURES:** I consent to the performance of surgery and/or procedures in addition to or different from those planned, whether or not arising from presently unforeseen conditions, which the above named physician/provider or associate may consider necessary or advisable in the course of the surgery or procedure including the use of additional medical practitioners as needed.

8. **BLOOD PRODUCTS:** I consent to the administration of whole blood or blood components. It has been explained to me that there is the possibility of ill effects including, but not limited to infection and other disease resulting from the administration of blood or blood components. I acknowledge and agree that neither the physician nor the Advocate facility provide any guarantee nor warranty with respect to the blood or blood components. *If patients requests bloodless procedure obtain patient signature on Refusal of Blood Administration Form*

9. **TISSUE USE:** I authorize the preservation and use for scientific or teaching purposes, or otherwise dispose of, the tissues, body fluids, or body parts resulting from the procedure and treatment authorized above.

10. **PHOTOGRAPHY:** I understand that the Physician/Provider may need to take photographs, video and or audio recordings to document a medical condition, help with the diagnosis and/or treatment and/or assist with the surgery/procedure. I also understand that these images may be used for advancing education with my/the patient’s identifiers not revealed.

11. **INDEPENDENT PHYSICIAN SERVICES:** I acknowledge and fully understand that the physicians who provide medical services to me at the hospital/facility ARE NOT EMPLOYEES OR AGENTS OF THE HOSPITAL/FACILITY, BUT RATHER ARE INDEPENDENT CONTRACTORS OR PRACTITIONERS. ONLY THOSE PHYSICIANS WHO HAVE EXPLICITLY AND CLEARLY IDENTIFIED THEMSELVES AS HOSPITAL/FACILITY EMPLOYEES ARE THE EMPLOYEES OF THE HOSPITAL/FACILITY. Non-employed physicians are independent practitioners WHO ARE PERMITTED TO USE THE HOSPITAL/ FACILITY TO RENDER MEDICAL CARE AND TREATMENT. Non-employed physicians include, but are not limited to, those practicing emergency medicine, trauma, cardiology, obstetrics, surgery, radiology, anesthesia, pathology and other specialties. I have been told that the hospital/facility does not control the medical decisions made by the independent physicians. These independent physicians exercise their own medical judgment in treating me or otherwise providing professional services to me and are solely responsible for their care and treatment. I understand that I should ask my physician any questions I may have about
his or her employment status. My decision to seek medical care at the hospital/facility is NOT BASED UPON ANY UNDERSTANDING, REPRESENTATION, ADVERTISEMENT, MEDIA CAMPAIGN, INFERENCE, PRESUMPTION, and OR RELIANCE THAT THE PHYSICIANS PROVIDING CARE AND TREATMENT TO ME ARE EMPLOYEES OR AGENTS OF THE HOSPITAL/FACILITY.

Patient/Legal Representative Signature:
My signature below constitutes my acknowledgement and agreement that I have read and understand the Consent Form information, was given an opportunity to discuss this form and ask questions, and that all questions were answered to my satisfaction. I understand that this consent may be revoked by me any time before the surgery/procedure is performed.

DO NOT SIGN IF YOU HAVE ANY QUESTIONS

Date: ________ Time: _______ Signed: ________________________________________________________

Patient/Legally Authorized Representative

Date: ________ Time: _______ Signed: ________________________________________________________

Witness Signature

Certificate of Interpretation:
I certify that I have interpreted the forgoing to signor hereof in the ____________________________ language.

Date: ________ Time: _______ Interpreter Signature: _____________________________________________

PHYSICIAN/PROVIDER SIGNATURE & INFORMED CONSENT AFFIRMATION:
My signature below affirms that prior to the time of the surgery/procedure that I have informed the patient or the patient’s Legally Authorized Representative of the medical condition requiring surgical treatment and/or procedure. I have explained the nature and purposes of the treatment or procedure, the complications and consequences, the reasonable possible alternatives and consequence of not doing the procedure, and the potential risks and benefits of each. I have also given the opportunity to ask questions and have answered any such questions.

Date: _______ Time: _______ Signed: _______________________________________________________

Operating Room NO CPR Orders/Limitation of Emergency Treatment (LET) Orders
The patient or his/her Legally Authorized Representative has discussed with the physician indicated below whether the patient’s NO CPR Orders/LET Orders should continue or be suspended during the planned surgery. The following has been decided:
(MARK ONE)

_____ The patient’s NO CPR Orders/LET Orders will continue in the Operating Room and during the perioperative period. Cardiopulmonary Resuscitation (CPR) will be provided to the patient in the event of cardiac arrest and all other LET Orders will be suspended in the Operating Room and during the perioperative period until the NO CPR Orders/LET Orders are reinstated

Date: ________ Time: _______ Signed: _______________________________________________________

Patient/Legally Authorized Representative

Date: ________ Time: _______ Signed: _______________________________________________________

Witness Signature

Date: ________ Time: _______ Signed: _______________________________________________________
Consent for Anesthesia Services

1. **AUTHORIZATION:** I authorize the provision of anesthesia services for myself/the patient, ____________________________ , related to the following surgical/invasive procedure(s): ____________________________________________________________

I understand that the Anesthesia services will be provided under the direction, supervision and authority of one of the following: Anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), or a physician credentialed to provide anesthesia services. I understand that at the time of the procedure that the anesthesia services may be provided by an associate of the below named provider and have been informed of this prior to the initiation of the procedure.

(Provider Name) ______________________________________________________________________________________

2. **OTHER QUALIFIED PRACTITIONERS:** I have been advised that anesthesia services may be performed by other medical practitioners under the direct or indirect supervision of the Anesthesia Provider or his/her associate. I understand that the qualified practitioners include but are not limited to residents, clinical students, allied health professionals or assistants and that they will only be performing those tasks within their individual skills/training.

3. **NATURE OF SERVICES:** I have had an opportunity to discuss the anesthesia services with the Anesthesia Provider and/or Associate. The nature of my condition, the nature and purpose of anesthesia services, the risks and benefits, any available, feasible treatment alternatives, possible complications and adverse outcomes including but not limited to severe disability or death has been explained to me. I do hereby assume all risks involved and understand that no guarantee or assurance has been given to me by anyone as to the results that may be obtained.

4. **PROVISION OF ANESTHESIA:**

I consent to the anesthesia services as checked below and authorize its administration for the procedure. I understand that the anesthetic technique to be used is determined by many factors, including my/the patient physical condition, the type of procedure, anesthesia provider preference, and my/the patient expressed preferences. It has been explained that it may require insertion of monitoring lines and catheters to safely administer the anesthesia which can have complications to blood vessels. I understand that anesthesia involves additional risk and hazards including serious, but rare, complications of breathing & heart problems, drug reactions, nerve damage, cardiac arrest, brain damage, paralysis or death. I understand that changes in the anesthetic may be necessary as my/the patient’s condition warrants and may have to be changed, possibly without explanation to me.

<table>
<thead>
<tr>
<th>Planned Anesthesia</th>
<th>Other potential complications or risks include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ General Anesthesia</td>
<td>Nausea; vomiting; injury to vocal cords, teeth, lips, eyes; awareness during procedure, memory dysfunction/memory loss; aspiration; permanent organ damage;</td>
</tr>
<tr>
<td>☐ Nerve Block</td>
<td>Nerve damage; persistent pain; bleeding/hematoma; infection; conversion to general anesthesia; incomplete analgesia, temporary motor weakness;</td>
</tr>
<tr>
<td>☐ Spinal</td>
<td>Nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; conversion to general anesthesia;</td>
</tr>
<tr>
<td>☐ Epidural</td>
<td>Nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; conversion to general anesthesia;</td>
</tr>
<tr>
<td>☐ Monitored Anesthesia Care (MAC)</td>
<td>Nausea; vomiting; memory dysfunction/memory loss; depressed breathing; increased awareness; anxiety or discomfort; conversion to general anesthesia;</td>
</tr>
<tr>
<td>☐ Deep Sedation</td>
<td>Nausea; vomiting; injury to vocal cords, teeth, lips, eyes; awareness during procedure, memory dysfunction/memory loss; aspiration; permanent organ damage; conversion to general anesthesia;</td>
</tr>
</tbody>
</table>
5. **PATIENT MEDICAL HISTORY:** I understand the importance in providing the anesthesia provider with a complete medical history, including the need to disclose any medications that I or the patient is taking, both prescription and over the counter. I also understand that any use of herbal remedies, alcohol or any type of illegal/recreational drug can result in serious drug interactions or complications and must be disclosed.

6. **INDEPENDENT PHYSICIAN SERVICES:** I acknowledge and fully understand that the physicians who provide medical services to me at the hospital/facility ARE NOT EMPLOYEES OR AGENTS OF THE HOSPITAL/FACILITY, BUT RATHER ARE INDEPENDENT CONTRACTORS OR PRACTITIONERS. ONLY THOSE PHYSICIANS WHO HAVE EXPLICITLY AND CLEARLY IDENTIFIED THEMSELVES AS HOSPITAL/FACILITY EMPLOYEES ARE THE EMPLOYEES OR AGENTS OF THE HOSPITAL/FACILITY. Non-employed physicians are independent practitioners WHO ARE PERMITTED TO USE THE HOSPITAL/FACILITY TO RENDER MEDICAL CARE AND TREATMENT. Non-employed physicians include, but are not limited to, those practicing emergency medicine, trauma, cardiology, obstetrics, surgery, radiology, anesthesia, pathology and other specialties. I have been told that the hospital/facility does not control the medical decisions made by the independent physicians. These independent physicians exercise their own medical judgment in treating me or otherwise providing professional services to me and are solely responsible for their care and treatment. I understand that I should ask my physician any questions I may have about his or her employment status. My decision to seek medical care at the hospital/facility is NOT BASED UPON ANY UNDERSTANDING, REPRESENTATION, ADVERTISEMENT, MEDIA CAMPAIGN, INFERENCE, PRESUMPTION, OR RELIANCE THAT THE PHYSICIANS PROVIDING CARE AND TREATMENT TO ME ARE EMPLOYEES OR AGENTS OF THE HOSPITAL/FACILITY.

**Patient/Legal Representative Signature:**
My signature below constitutes my acknowledgement and agreement that I read and understand the Consent Form information, was given an opportunity to discuss this form and ask questions, that all questions were answered to my satisfaction, and I am satisfied I understand the form’s contents and significance. I understand that this consent may be revoked by me any time before the anesthetic is given.

**DO NOT SIGN IF YOU HAVE ANY QUESTIONS**

Date: _______ Time: _______ Signed: ______________________________________________________

Patient/Legally Authorized Representative

Date: _______ Time: _______ Signed: ______________________________________________________

Witness Signature

**Certificate of Interpretation:**
I certify that I have interpreted the forgoing to signor hereof in the ____________________________ language.

Date: _______ Time: _______ Interpreter Signature: _____________________________________________

**ANESTHESIA PROVIDER SIGNATURE & INFORMED CONSENT AFFIRMATION:**
My signature below affirms that prior to the time of the procedure that I have informed the patient or the patient’s Legally Authorized Representative, of the methods of anesthesia proposed. I have explained the nature and purposes of the anesthesia, the complications and consequences, the reasonable possible alternative anesthesia methods and the potential risks and benefits of each. In addition I have described the anesthetic to be used and indicated that an alternative form of anesthesia may be used if required by unexpected conditions arising before or during the procedure. I have also given the opportunity for the patient/authorized representative to ask questions and have answered any such questions.

Date: _______ Time: _______ Signed: _______________________________________________________