UNITY HEALTH SYSTEM

Consent for Surgical Procedure or Invasive Procedure

I authorize Dr. _____and his/her assistants to perform upon _____
the following procedure (describe in layman's terms & note implant system to be placed or device to be removed if applicable):

_____

_____

_____

Also, Dr._____and his/her assistants are expected to perform the following procedure:

_____

The nature and purpose of the procedure, the most common risks involved, and the possibility of complications (listed):_____

_____

_____

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 (listed):

_____

_____

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 operation 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.

For those procedures that have the potential for significant blood loss: I consent to the transfusion of blood or blood components that may be necessary before, during or after the procedure. I have been informed that no transfusion is 100% safe, however present testing methods make the risks very small. Risks include infection from viruses, bacteria or parasites, including but not limited to HIV (the AIDS virus) and hepatitis, as well as fever, chills, allergy, volume overload or death. I have discussed possible alternatives with my care provider, including no transfusion, autologous transfusion (donation of my own blood), designated/directed donor transfusion (collection of blood from donors selected by me) or blood salvage during the procedure. I understand that these alternatives may not be available due to timing or health reasons, and that the above risks may still apply.

I consent to the use of donor tissue and tissue products if they are necessary for my treatment.

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:

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*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.

Signature:_____ Date:_____

Relationship: ☐ Patient ☐ Parent/Guardian ☐ Other (relationship to patient):_____

☐ An interpreter service was used in completion of the Consent.

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)

If faxing this form, please fax both sides. Patient's name must be on each side of the form.

Rev. 7/16/12 PS1000122

Universal Protocol: Preventing Wrong Site, Wrong Procedure and Wrong Person Procedure

Pre-an/pre-procedure (Nursing to complete)
Required Documentation is present: □ Signed consent complete
If applicable: □ Pre-anesthesia or pre-sedation assessment □ Cardiology images □Diagnostic images
□ Pathology and biopsy reports, all properly labeled □ Required blood products □ Implants, devices, special equipment

Date:				
Prep Room:	Patient Identifier	Operation/Procedure	Verification Components	Signature
Pre-Procedure Timeout: Time	Patient/SO states Name/DOB	❑ Gastroscopy ❑ Colonoscopy ❑ ERCP ❑ Bronchoscopy Other _____	Patient and Procedure verified Site not marked, reason Single organ or body part	Pre-Procedure Room Nurse
Procedure Room: Pre-Procedure Timeout: Time	Diagnosis	❑ Gastroscopy ❑ Colonoscopy ❑ ERCP ❑ Bronchoscopy Other _____	Correct Patient Position	Procedure Room Nurse

H & P has been reviewed prior to procedure and updated as needed.

Time out has been performed per protocol.

Proceduralist Signature_____