Methodist Le Bonheur Healthcare

(Place Patient Identification Sticker Here)

Surgery/Procedure/Treatment Consent Form

"Surgery" means a medical service performed by a doctor, typically in the operating room setting. "Treatment" or "procedures" are care that may be done in a special setting. Some surgeries, procedures, and treatments may be done at the bedside. Doctors in training may be assisting and performing portions of the surgery. Other licensed providers (nurse practitioners, physician assistants, nurses) may perform certain treatments or procedures without a doctor present.

Dr./Mr./Ms. _____ and their assistants or doctors in training have permission to perform the following surgery, procedure, or treatment:

_____

_____

Site of surgery:_____ Side of surgery (circle one, if applicable): Right Left

I understand that new findings during the surgery or procedure may make it necessary to perform additional surgery or procedures before the end of the case.

The doctor or provider has talked to me about:

- The surgery, procedure, or treatment that is being performed
- The need for the surgery, procedure, or treatment
- Possible benefits and risks, and how likely there will be benefits or risks for having the surgery, procedure, or treatment
- Other options for the surgery, procedure, or treatment and likelihood of benefits and risks for each option
- What might happen if the surgery, procedure, or treatment is not performed
- I have not been promised certain results from my surgery, procedure or treatment.
- If doctors in training, medical, or nursing students will help with my surgery, procedure or treatment
- The type of problems that may develop in the facility and after discharge from the facility
- Limitations of activity and healing times after my surgery, procedure, or treatment in the facility and after discharge
- What medicine will be used to help with pain in the facility and after discharge
- The possible need for a blood transfusion or blood products during and after the surgery, procedure, or treatment. Blood products may be needed because medicines or diet may not be enough treatment.
- Blood products are tested, but there is the risk of getting:
  - Infectious diseases, such as hepatitis or HIV (human immunodeficiency virus)
  - Mild transfusion reaction causing fever, chills, or rash
  - Serious transfusion reaction including heart, lung, kidney or liver problems
  - In rare cases, death may occur.

❑ **I do not give permission to receive Blood Products.**

- Advanced directives (DNR and POST forms) will be respected; treatments that directly support the surgery, procedure, or treatment may be a special case.
- If medicines are needed for sleep (anesthesia) or to numb my body parts, then another doctor or nurse will provide an extra form about the medicine.

My doctor has told me that my surgery, procedure or treatment may overlap during the time my doctor has to do other medical services. A doctor in training or assistant will be present in my doctor's absence.

- My doctor may not be present for all of my surgery, and may not be present at all during my procedure, or treatment.
- My doctor will be present for all critical portions of my surgery or procedure.
- My doctor or qualified provider will be available without delay at all times, if needed.

Other necessary tests such as x-rays, lab tests and tissue biopsies may be performed during the procedure.

Skin, muscle, bone, or other body parts may be removed to learn more about my problem. These body parts may be used for medical learning or thrown away, based on hospital policy.

Medical or nursing students may watch with the surgery, procedure, or treatment (for medical learning).

Medical device vendors may help with device assistance.

Pictures or videos during the surgery, procedure, or treatment (for medical learning) may be taken. My identity will be protected.

I understand this form and my surgery, procedure, or treatment.
My doctor or licensed provider has answered all my questions about my surgery, procedure, or treatment.

❑ A translator was present when I gave my doctor permission to do my surgery, procedure, or treatment.

_____	_____	_____
Signature of patient, parent, legal guardian, or surrogate decision maker	Date	Time
_____	_____	
Relationship of person signing for patient	Signature and title of witness	

FOR ASSOCIATE USE ONLY: Date of Time Out: _____ **Time of Time Out:** _____
TIME OUT – Announced immediately prior to start of procedure
❑ Correct Patient ID ❑ Correct site / (side, if it applies) ❑ Correct procedure
FOR ROBOTIC PROCEDURES: Date of Second Time Out: _____ **Time of Second Time Out:** _____
TIME OUT – Announced immediately prior to excision of any body part or tissues
❑ Correct site / (side, if applicable) ❑ Correct specimen
Signature: _____

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