Methodist
Le Bonheur Healthcare

(Place Patient Identification Sticker Here)

CONSENT FORM FOR SURGERY / SPECIAL PROCEDURE AND / OR TREATMENT

I authorize and direct Dr. _____ and the associate/assistants, residents, or other physicians in training, of his/her choice to perform the following surgery / special procedure, and /or treatment:

_____

_____

And such additional therapeutic surgery / special procedure and / or treatment as his/her judgment may indicate on the basis of findings during the course of said surgery / special procedure and / or treatment. I have identified that _____ is the correct surgery / special procedure and / or treatment site/side. Dr. _____ has fully explained and discussed with me the following:

- Surgery / special procedure and / or treatment to be performed;
- Nature and purpose of the surgery / special procedure and / or treatment;
- Significant risks which may be involved;
- Possibility that complication may arise or develop;
- Possible alternate methods of treatment;
- Potential need for transfusion of blood/blood products during and after the procedure
  - Alternatives for blood products, such as medication or diet, may not be sufficient treatment
  - Although blood products are tested, receiving blood includes the risk of:
    - Infectious diseases such as, but not limited to, hepatitis or human immunodeficiency virus (HIV).
    - Mild transfusion reaction causing fever, chills, or rash
    - Serious transfusion reaction including heart, lung, kidney, or liver problems and, in rare cases, death
- Prognosis if no treatment is received and no warranty or guarantee has been made as to the results of care received; and
- Any advance directives (including a DNR order or POST) will be honored except for those interventions and treatments deemed necessary for immediately supporting the procedure.

I authorize and direct the above named physician or dentist and his/her associates/assistants, residents, or other physicians in training, to provide and/or arrange for the provision of such additional services as they deem reasonable and necessary including, but not limited to the performance of services including pathology and radiology and the transfusion of blood/blood products. Any tissues, blood specimens, or other parts surgically removed may be retained or disposed of by the hospital in accordance with its accustomed practice.

I authorize and direct the above named physician, dentist, resident, or other to administer sedation/anesthesia or to arrange for the administration of sedation/anesthesia by a member of the Anesthesiology Department and/or his/her designee. The alternatives to and risks of sedation/anesthesia administration have been fully explained and discussed with me by my physician, anesthesiologist, or his/her designee.

- During the procedure, I consent to films or photographs my physician or dentist may make or request. I also consent to observation, in person or by remote video or electronic media viewing, during the surgery/special procedure/treatment by residents, or medical personnel in training or by other appropriate persons permitted by my physician or dentist and authorized by the hospital."
- I also understand that at my physician's discretion, non-identifying videotaping or photographs may be taken during the course of the procedure for documentation or educational purposes. These images may be released to the provider(s) for their professional use. I understand that no accompanying text or identifying imagery (face, name, or unique characteristics) may be released by those providers without my expressed consent.

I hereby state:

- I have read and understand this Consent Form and, additionally, I understand my right to refuse this procedure / treatment.
- all my questions about the surgery / special procedure and / or treatment have been answered in a satisfactory manner;
- all blank spaces were filled in or deleted prior to my signature; and
- My signature indicates that I have received informed consent from my physician and consent to this procedure / treatment.

_____ _____

Signature of patient, parent, legal guardian, or surrogate decision maker | Today's date and time

_____ _____

Relationship of person signing for patient | Signature / 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 applicable)** ❒ **Correct Procedure**

Signature: _____

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