Informed Consent

Informed Consent for Medical Treatment, Surgical and Other Procedures and Services

[To be completed by provider responsible for the treatment, operation or procedure]

ALASKA REGIONAL HOSPITAL

I give consent/permission to Dr. _____ **and/or** any other doctors or assistants as needed to help in performing the treatment, operation or procedure ("surgery") my doctor recommended. I understand that other health care practitioners may aid in this surgery.

OTHER PRACTITIONERS: ❑ None ❑ Medical Student/Resident ❑ Physician's Assistant/Nurse Practitioner

❑ Doctor ❑ Surgeon's Assistant/Nurse First Assistant ❑ Other _____

SIGNIFICANT PROCEDURE OR TASK PERFORMED BY OTHER PRACTITIONER:

❑ Opening / Closing ❑ Removing Tissue ❑ Prosthetic Devices ❑ Other
❑ Harvesting Grafts ❑ Altering Tissue ❑ Line Placement
❑ Cutting Tissue ❑ Implanting Devices ❑ All Preceding Tasks

PROCEDURE: (medical term for procedure): _____

_____

_____

on my ❑ N/A ❑ Right ❑ Left ❑ Bilateral body part

The surgery or procedure being performed is: (Description in lay terms)

_____

_____

_____

I understand the reason(s) for the surgery is (are) _____

_____

_____

RISKS: I understand that any surgery may have risks and hazards. My doctor discussed with me why I need the surgery and explained what will happen during the surgery. My doctor told me about the risks, benefits, and possible discomforts, including any problems related to having surgery. The more common risks include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions and pneumonia. These risks can be serious and may possibly cause death. I understand these and other risks and complications are not likely results, but they could happen. I have had the healing process, hospitalization and the likely time it will take me to recover explained to me. I understand that I do not have a guarantee or promise about the results of the surgery and that it may not cure the condition. The doctor told me about other methods of treatment, and the risks, benefits and possible side effects of these alternatives.

I understand that if I DO NOT HAVE the surgery, the following risks (or more) could happen:

❑ **Continued symptoms/condition and/or (listed below):** _____

_____

_____

ADDITIONAL PROCEDURES: If my doctor finds a different, unsuspected condition at the time of surgery, I give him/her permission to do what treatment he/she thinks appropriate. I also give the doctor permission to tell my family or decision maker if this should happen.

ANESTHESIA / SEDATION: Having a surgery with anesthesia or sedation medications can have risks, most importantly, there is a rare chance that a reaction to the medication could cause death. I give my doctors, or other medically qualified persons under proper supervision, permission to give me the medications needed for my surgery.

(Physician Office Fax Use Only)

TREAT _____ _____

Patient Date of Birth

Patient Label

BLOOD TRANSFUSION/BLOOD PRODUCTS: The doctor explained to me that I may need to receive blood or blood products during my surgery. I give my permission for the use of blood transfusion or blood products as my doctor thinks needed. I understand that there are risks associated with blood transfusions or blood products including, but not limited to, unexpected allergic reaction, or infection, such as hepatitis or AIDS.

❑ N/A

❑ I give my permission for transfusion of blood or blood products. **(Patient Initials):** _____ **Date:** _____**Time:** _____

❑ I DO NOT give my permission for transfusion of blood or blood products. **(Patient Initials):** _____ **Date:** _____**Time:** _____

DISPOSAL OF TISSUES: I understand that the hospital may examine and dispose of, or keep for medical purposes, any tissues or parts removed during the surgery.

IMPLANTS: If my surgery involves putting in a medical device, I give permission to give my social security number to the manufacturer, if necessary, to meet the regulations for tracking the device.

RESUSCITATION RECONSIDERATION DISCUSSION: THIS SECTION ONLY APPLIES TO PATIENTS WITH ADO NOT RESUSCITATE (DNR) ORDER or PROVIDER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST)

❑ N/A - Does not apply to this case.

❑ I have discussed suspension of my DNR with my provider and agree to receive life sustaining treatments during the perioperative time period (operating room, procedural areas and recovery room).

❑ I have discussed suspension of my DNR with my provider and wish to keep my DNR in effect at all times.

PHOTOGRAPHS/VIDEO: I understand that surgery site specific photographs/videotaping may be taken during the surgery and that my privacy and identity will be protected. I also understand that my surgery may be photographed or videotaped for purposes of documentation and that these photographs/videotaping may help the quality of care or be used for medical science and education.

CRITICAL COMPONENT:
My doctor told me that my scheduled surgery overlaps with another surgery he/she is scheduled to perform. I understand this means my doctor will be in the operating room during the critical parts of my surgery, but may not be in the operating room for my entire surgery. My doctor also told me that he/she will supervise a surgical team and that some members of this surgical team will perform parts of my surgery. I understand that my doctor or another qualified doctor will be immediately available should the need arise during my surgery. My doctor has answered all my questions about this overlapping surgery and I give my permission.

CRITICAL COMPONENT: ❑ N/A or ❑ I authorize

TREATING PROVIDER'S STATEMENT: The patient or their surrogate decision-maker and I have discussed the surgery. The discussion included the risks, benefits, complications and alternatives of both the procedure and blood products that may need to be administered. To the best of my knowledge, the patient or decision-maker understood the discussion, all questions have been asked and answered, and the patient or decision-maker consents to the procedure and transfusion decision.

Provider Signature: _____ **Date:** _____ **Time:** _____

PATIENT OR GUARDIAN'S CONSENT: I have read and fully understand this consent/permission form, and understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words in this consent form. I understand the risks and benefits of this surgery and give my consent to this surgery. I understand the importantparts of the process for getting ready for surgery. If I have any questions about that process, I have asked those questions and they have been answered to my satisfaction. **Note:** The patient or patient legal representative may withdraw his/her consent/permission before the surgery begins.

Patient Signature: _____ **Date:** _____ **Time:** _____

If not signed by Patient, please indicate authority to consent: ❑ Parent ❑ Surrogate Decision-Maker

(Physician Office Fax Use Only)

TREAT _____ _____
Patient Date of Birth

Patient Label