ENGLEWOOD HOSPITAL
AND MEDICAL CENTER

CONSENT FOR MEDICAL/SURGICAL PROCEDURES

Patient Label _____

Anticipated Date of Procedure: _____

1. I authorize Dr. _____
(State all names, if authorizing a Group)
("Physician"), together with other qualified assistants named below to perform the following procedure(s):

_____

_____

_____

Assistants: _____ on _____
(Name of patient or "myself)
for treatment of the following diagnosis(es):_____

_____

2. I understand that Englewood Hospital and Medical Center is a teaching institution and that residents, teaching fellows and/or medical students may participate or assist in the above listed procedure(s) under the supervision of the Physician. In addition, other qualified assistants may be present to assist the physicians. I also understand that the rotation of these persons makes it difficult to identify in advance the particular person(s) who may assist or participate in this procedure(s). I understand that if possible I will be informed of the identity of any such person(s) prior to the procedure.

3. Dr. _____ has discussed with me the ideas that are briefly summarized below:
   a. The nature and purpose of proposed procedure.
   b. The risks of proposed procedure(s), including the risk that such procedure may not improve my condition.
   c. The possible or likely results of the proposed procedure.
   d. Alternative ways of treatment (including the risks, consequences, and probably effectiveness of each).
   e. The prognosis if no treatment is received.

4. I have also been informed that all invasive procedures may involve other risks such as severe blood loss, infection, cardiac arrest, instrument and/or equipment failure and death.

5. I have also been informed that sometimes during invasive procedures it is discovered that additional or other procedure(s), not known to the Physician before the procedure, is/are necessary. If such occurs during my procedure, I specifically authorize the Physician to perform such additional or other procedure(s).

6. I understand that occasionally observers may be present in the Operating Room for technical or educational purposes, and I consent to the presence of same during the procedure(s) to be performed on me.

7. I understand that occasionally my procedure and/or portions of my procedure may be photographed and/or videotaped for educational purposes within and outside of the Medical Center. At no time during this process will my identity (or any information linked to my identity) be revealed. The actual film or videotape will remain in the physical possession of the Medical Center or my personal physician at all times and will not be released to any other person, agency, or institution unless I specifically authorize it. I consent to the use of photography/videography. I reserve the right to stop filming/video at any time to rescind permission for publication.

8. **I GIVE ❑ I DO NOT GIVE ❑ NOT APPLICABLE ❑**
my physician permission to transfuse me with blood or blood products. I understand that there are risks associated with receiving blood, including but not limited to, hepatitis, AIDS, fever or allergic reaction. I acknowledge that the risks and benefits of this treatment have been explained to me and that all alternatives to blood transfusion have been explained. I understand that no expressed or implied warranty has been given by the hospital, any blood bank, or any person or entity as to the blood or blood components transfused. For elective procedures, I have also been informed of the various options of autologous (donation of my own blood), directed donor (donation of someone else's blood for me) and volunteer blood transfusions, which may be used during my procedure. I have been given adequate time to make the necessary arrangements for these options, or I have waived their use. This permission is granted by me for 24 hours after my surgery.

Patient Name: _____ MR#: _____

9. Any tissues, organs, or implants removed may be disposed of by the Hospital according to the usual procedures.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me by anyone as to the results that may be obtained from the performance of this procedure.

I certify that I have read, fully understand, and consent to the above procedure(s), that the explanations referred to above were made, and that all blanks and statements requiring insertion or completion were filled in, and inapplicable paragraphs, if any, were stricken (and initialed by both me and the physician) before I signed this consent.

Signature of Patient	Date/Time	Witness to Signature
Signature of Health Care Representative or other Responsible Person (in case of patient's inability to consent or patient is a minor)	Date/Time	Relationship to Patient

*AND TRANSLATOR IF NEEDED

Translator Signature	Date / Time

The above procedure has been fully explained to Patient or Person signing consent. (Signature of Physician)*

Signature of Physician	Date/Time

NOTE: NOT REQUIRED IF MODERATE SEDATION IS PROVIDED BY ANESTHESIA

TIME OUT is a pause prior to initiating a procedure to assure the safety of the patient by confirming the following elements:

I attest that a TIME OUT has been conducted in the location where the procedure is/was performed prior to the procedure being initiated, as evidence by the informed consent, according to the criteria below.

Correct patient Correct procedure Correct site
Correct position Correct diagnostics
Correct supplies/equipment

Physician _____

Date _____ Time _____

FOR PATIENTS REQUIRING MODERATE SEDATION: I understand that I will require Moderate Sedation so that my physician can safely perform the planned procedure with less pain, anxiety and awareness. Medication will be given into the intravenous line (or possibly orally, in children), and I will be carefully monitored in accordance to the standards and policy of this Medical Center.

Possible risks include, but are not limited to: an unconscious state, depressed breathing, cessation or respiration or, change in blood pressure, heart rate or heart rhythm. Although these complications are rare, pneumonia, death, coma or permanent brain damage can occur.

The risks of not accepting Moderate Sedation may include increased pain, anxiety, as well as not being able to complete the procedure or obtain as much information as desired.

I acknowledge that the risks, benefits and alternatives to moderate sedation have been explained to me. I give my physician permission to administer moderate sedation to me.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me by anyone as to the results that may be obtained from the performance of this procedure.

I certify that I have read, fully understand, and consent to the above procedure(s), that the explanations referred to above where made, and that all blanks and statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken, (and initialed by both me and my physician) before I signed this consent.

Signature of Patient	Date/Time	Witness to Signature
Signature of Health Care Representative or other Responsible Person (in case of patient's inability to consent or patient is a minor)	Date/Time	Relationship to Patient

The above procedure has been fully explained to Patient or Person signing consent. (Signature of Physician)*	Date/Time

*AND TRANSLATOR IF NEEDED

Translator Signature	Date / Time