UM Upper Chesapeake Health

PATIENT ACKNOWLEDGMENT AND CONSENT

Place Patient Label

_____

Patient Name: _____ Date of Procedure: _____

I have reviewed this copy of "Surgical/Procedure Risks" and had the opportunity to talk with my provider about the benefits, potential outcomes, and likelihood of achieving the goals of the planned procedure(s); risks and possible complications; alternatives to the procedure, including the risks and benefits associated with no treatment; and, possible problems that may occur during my recuperation. I have been thoroughly informed, and had all of my questions answered.

I understand that my diagnosis is: _____

I have consented to the following by, or under the supervision of: _____:

1) Planned Procedure(s) _____

_____

_____

2) Any other procedures necessary to address conditions that are discovered during the procedure(s) listed above;
3) Disposal or retention of any tissues removed during the procedure;
4) Pictures or videotape being taken during the procedure so long as my identity is not revealed;
5) Observers for medical education being present in the operating room.

_____ _____ & _____

Signature of Patient ** Date Time

_____ _____ & _____

Signature of Witness to patient/representative signature Date Time

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PROVIDER CERTIFICATION

I certify that a discussion about the details listed above have been explained to the patient, or their Authorized Representative, by a provider performing the procedure, and an informed consent obtained.

_____ _____ & _____

Signature of Provider (Phys / Dentist / Podiatrist / AHP) Date Time

Dictation ID #, Printed Name or Stamp: _____

**** IF PATIENT IS UNABLE OR INCAPABLE OF CONSENTING, HAVE APPROPRIATE REPRESENTATIVE SIGN:**

_____ _____ _____ & _____

Authorized Representative Signature Relationship to Patient Date Time

Document reason patient is unable to sign

- ☐ (1) Pt has a Designated Healthcare Agent on Medical POA or Advanced Directive
- ☐ (2) Pt is unable to communicate (Unconscious, Intoxicated, Sedated, etc.)
- ☐ (3) Pt lacks Capacity to Understand (Requires 2 Phys certification of incapacity)

** If an Anesthesia Consent is <u>not</u> required for this procedure, and the patient is DNR, the advanced directive section on the back of this f~~r~~o<u>r</u>m is to be completed**

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Directive Limiting Treatment (Check one of the boxes)

☐ **Do Not Resuscitate**

☐ **Limited Resuscitation**

I wish to limit treatment:

	Accept	Refuse
Intubation		
Chest Compression/Cardiac Massage		
Defibrillation (electric shock to the heart)		
Cardiac Pacing (internal/ external)		

Patient / Surrogate Signature: _____ Date_____ Time:_____

Provider Signature: _____ Date_____ Time:_____

Witness Signature:_____ Date_____ Time:_____

SURGICAL/PROCEDURE RISKS

This sheet explains some important general information about procedures which you should read before giving your consent. The physician performing or supervising your operation/procedure will give you more detailed information about your specific procedure.

MEDICAL TERMINOLOGY: Your physician/practitioner can and will explain your proposed procedure(s) using terms which you can understand. Sometimes s/he may use medical terms that are not common words. If you have any questions about what any words may have meant or anything else about the procedure you should ask your physician/provider to explain them until you fully understand the planned procedure.

RISKS OF SURGERY: All operations carry with them certain risks, including failure to obtain the desired result, discomfort, injury, additional therapy, bleeding, infection and in rare instances, death. You should discuss these risks, possible complications, and any alternatives to the procedure, with the physician/provider performing the procedure.

UNANTICIPATED CONDITIONS: During the course of an operation conditions may be encountered other than those anticipated before the surgery. A different organ may be found to be the source or cause of symptoms. Your surgeon may be required to perform a different operation than planned because of these unanticipated findings.

TISSUES REMOVED DURING SURGERY: Special doctors at the hospital (pathologists) will examine tissues removed during your surgery. Usually, after examination, the tissue is disposed of in a medically acceptable way. Occasionally tissues are retained for teaching or research purposes.

PICTURES: Photographs and videotapes of your operation and conditions may be taken and used for documentation and education. Your identity is not revealed by the pictures or descriptions accompanying them. Occasionally, closed circuit television transmission of the operation is used for educations purposes.

OBSERVERS: Students, visiting doctors and medical equipment representatives may be present during your surgery for teaching purposes. Your privacy is respected by all who are allowed to be present.

NO GUARANTEES: The practice of medicine and surgery is not an exact science and results cannot always be anticipated. No guarantees can be made to you concerning the course, duration or results of your surgery by your surgeon or anyone else at UM-UCHS.