Piedmont HEALTHCARE

CONSENT TO SURGICAL, DIAGNOSTIC, THERAPEUTIC, BLOOD TRANSFUSION OR TISSUE IMPLANTATION PROCEDURE(S)

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

PATIENT NAME:_____ **DATE OF BIRTH:**_____ **HOSPITAL:**_____

The following has been explained to me in general terms and I understand that:

1. The **diagnosis** requiring this procedure(s) is:_____

2. The **procedure(s)** is/are:_____

3. The **nature and purpose** of this procedure(s) is/are: (specific for this patient):_____

4. **Practical alternatives** to the above procedure(s) and their risks and benefits are: ☐ None ☐ Other:_____

5. **Material risks** of this procedure(s) being performed may include: PAIN, INFECTION, ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OF ANY LIMB OR ORGAN OR LOSS OF ITS FUNCTION, PARALYSIS OR PARTIAL PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC ARREST OR DEATH. Other possible risks of this procedure(s) include, but are not limited to:_____

6. The **likelihood of success** of the above procedure(s) is: ☐ Good ☐ Fair ☐ Poor ☐ Unknown

7. If I choose not to have the above procedure(s), my **prognosis** (future medical condition) is: ☐ Good ☐ Fair ☐ Poor ☐ Unknown

8. I hereby voluntarily request and consent to the performance of the procedure(s) described/referenced herein by:_____, M.D. and such other physicians, including but not limited to residents, fellows and physicians-in-training, under his/her supervision or other qualified medical professionals as are needed to assist him/her to perform the procedure(s). I understand that these practitioner(s) will assist him/her in performing the procedure(s) and that the practitioner(s) will perform only tasks that are within their scope of practice and privileges and in accordance with hospital policies. I understand that not all practitioner(s) may be known at the time this consent is given. I consent to and authorize the physician to involve those practitioner(s) he/she deems necessary to perform significant surgical tasks, and procedures, including, but not limited to, opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices and altering tissues.

9. I understand that during the course of the procedure(s), unforeseen conditions may arise that require an extension of the original procedure(s) or different procedure(s) from what is listed in Paragraph 2. I request that the physician named in Paragraph 8 and/or his/her assistant or designee, perform the procedure(s) that appear necessary in their judgment. The authority granted under this Paragraph 9 extends to treating all conditions that require treatment but are not known at the time the procedure(s) is started.

10. I consent to the administration of anesthesia/IV sedation under the supervision of my physician or the anesthesiology group and the use of such anesthetics as may be deemed advisable. If appropriate, sedation may be used which involves the administration of a drug or drugs that will depress consciousness during a surgical/diagnostic procedure. I understand that prior to the administration of anesthesia, I will have an opportunity to discuss the associated risks and alternatives with the medical provider who will administer the anesthesia/sedation or his/her designee.

11. I consent to the use of a direct arterial, central venous or pulmonary artery catheter(s) if my physical condition, or the nature of the procedure(s), necessitates such use.

12. I consent to diagnostic studies, tests, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedure(s) described herein.

PATIENT NAME:_____ **DATE OF BIRTH:**_____ **HOSPITAL:**_____

13. *****I consent that any tissues, specimens, organs, limbs or parts removed from my body in the course of any procedure(s) may be retained by, preserved, tested and/or otherwise used by Piedmont Healthcare and its affiliates, physicians, agents or employees for scientific or teaching purposes and then disposed of within the discretion of Piedmont Healthcare and its affiliates, physicians, agents or employees.

14. *****I consent to the photographing, audio-visual recording and/or televising of the procedure(s), including appropriate portions of my body, to be used for medical, educational or scientific purposes or other reasons of my choice.

15. *****I consent to the presence of observers during my procedure(s) as approved by my physician for medical, scientific or educational purposes, or other reasons of my choice.

16. *****The FDA has ordered that manufacturers track the medical device that I may receive. I understand that I may refuse permission to release my name, address, telephone number, and social security number or other identifying information to the device manufacturer. I understand that by refusing permission to release my confidential information to the manufacturer, there could be a delay in my being contacted regarding a possible problem with the device. I understand that such a delay could negatively impact my health.

17. I am aware that the practice of medicine and surgery requires the use of disposable and non-disposable equipment and instrumentation that may or may not be reprocessed by a third party vendor as required by the FDA.

18. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me about the results of the procedure(s).

19. Some of the healthcare professionals performing services in this hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors.

CONSENT FOR BLOOD PRODUCTS/BLOOD DERIVATIVES/TISSUE/TISSUE DERIVATIVES

To Be Completed for Surgical and/or Medical Patients as Applicable

I understand that blood/blood products transfusion(s) or tissue may/will be required during my surgery, treatment or procedure(s) to treat blood loss. Although the blood products or tissue to be administered have been prepared and tested in accordance with procedures established by the American Association of Blood Banks and the FDA, there is still a very small chance the above products will be incompatible with my/the patient's body and a transfusion reaction can occur. Although transfusion reactions can be treated successfully, I understand that on very rare occasions they can be fatal. I understand that allergic reactions to blood products such as hives, itching and fever are more common, but can be treated. I understand that even with testing by the most up-to-date methods, there is a small chance the blood products may contain a pathogen that will enter my system and may not be recognized as an infection for many months or years. Alternatives to transfusion, including administration of my own previously donated blood (if applicable), have been discussed. I understand that this consent will remain valid for the length of my current inpatient hospitalization or as long as I am being transfused to treat the same condition as an outpatient.

☐ Not Applicable for this procedure.

☐ I CONSENT to the administration of blood products and/or tissue implantation.

☐ REFUSE CONSENT to receive blood products and/or tissue implantation as recommended by my physician(s) and accept full responsibility for any consequences which may result from such refusal.

PATIENT CONSENT

By signing this form, I acknowledge that the risks, benefits and alternatives to the above procedure(s) have been explained to me and that I have read or had this form read and/or explained to me in general terms, that I fully understand its contents, that I have been given ample opportunity to ask questions and that any questions have been answered or explained satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form. I also have received additional information including, but not limited to, material relating to the procedures(s) described herein.

I REQUEST AND CONSENT TO THE PERFORMANCE OF THE PROCEDURE AS OUTLINED ABOVE.

_____ Date:_____ /Time:_____ _____

Signature of Patient/Authorized Representative — If not patient, relationship to patient

Name of person giving consent (print):_____ Patient unable to sign because:_____

Witness to Signature (print):_____/Signature:_____ Date:_____/Time:_____

***If patient does not wish to consent to items no. 13, 14, 15 or 16, he/she may line through and initial any or all.**

RESPONSIBLE PRACTITIONER STATEMENT

☐ **Interpreter services were used to obtain this informed consent. The patient/representative had the opportunity to ask questions.**

I have reviewed the contents of this form, including risks, benefits and alternatives to the proposed procedure(s), with the patient and/or patient's authorized representative. The patient and/or patient's authorized representative has indicated understanding and consented to the procedure described above.

Practitioner Name (print):_____/Signature:_____ Date:_____/Time:_____