Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

CONSENT • CONSENT TO OPERATION, PROCEDURE AND ADMINISTRATION OF ANESTHESIA

PLEASE READ THE ENTIRE FORM CAREFULLY BEFORE SIGNING.

Any operation or procedure may involve the risk of an unsuccessful result or complication, including but not limited to bleeding, infection, nerve/nervous system damage, injury to organs/structures or even death from both known and unforeseen causes. You have the right to be informed about your proposed care, treatment, services, medications, interventions, operation or procedure, and its risks, benefits, side effects, potential problems related to recuperation, and the likelihood of achieving your care, treatment, and service goals.

Except in an emergency, an operation or procedure is not performed until I have had the opportunity to receive this information and have given my consent. I understand that in an emergency there may be different or further procedures required if the doctor believes they are necessary. I also understand that the operation or procedure may involve the use of a Food and Drug Administration (FDA) approved drug or device for a purpose not approved by the FDA. I understand that other medical care will not be withheld if I decide to withhold or withdraw my consent to this proposed treatment.

In addition to caring for patients, Stanford Hospital and Clinics (SHC) and Lucile Packard Children's Hospital (LPCH) are educational institutions. As part of the medical education and training program, postgraduate fellows, residents, medical students, surgical assistants and approved health care practitioners may observe care, and if appropriately trained, participate in aspects of the operation or procedure. These practitioners will be under the supervision of the attending doctor. Furthermore, if the procedure involves specialized equipment or medical device(s), the manufacturer's representative(s) may be present during the procedure to assist in the selection or calibration of the equipment or device(s) and in the related treatment.

Your signature on this form authorizes the hospital to use and/or dispose, at its discretion, any blood, bodily fluid, member, organ, or other tissue removed or obtained during your operation, procedure, or treatment, for research that may be conducted by SHC, LPCH, Stanford University, or unaffiliated academic or commercial third parties if allowed under legal requirements and relevant policies. The following operation or procedure will be carried out by the practitioners identified on this form along with associates and assistants, including anesthesiologists, pathologists and radiologists from the medical staff.

PATIENT/PROPERLY DESIGNATED REPRESENTATIVE: By my signature below, I confirm that:

1. I have read and understand the information provided on this form, and the nature and purpose of the operation or procedure have been explained to me. The risks and benefits of the operation or procedure have been explained to me. In addition, the alternatives, the risks and benefits of these alternatives and the risks of having no treatment have been explained to me. I have had the opportunity to ask questions and have received all the information I desire about the operation or procedure.
2. I understand that in an emergency there may be different or further procedures required if the doctor believes they are necessary, and I consent to such procedures.
3. I understand that the administration of anesthesia and/or moderate sedation and associated procedures may be necessary to assure safety and comfort during the procedure and I consent to such procedures if indicated. I understand that certain risks and complications may be associated with the use of anesthesia and/or moderate sedation and the associated procedures, and that the appropriate practitioner will discuss these risks with me prior to the procedure.
4. If the practitioner has informed me that blood use is anticipated, I understand that the risks associated with the use of blood and/or blood products include reactions, transmission of disease, and unforeseeable risks including death. I consent to the use of blood or blood products during the operation or procedure and subsequent hospitalization if indicated.
5. **I do not consent to the use of blood or blood products. I understand I must notify my physician immediately and will be asked to sign the Refusal to Permit Blood Transfusion form. _____ (Please initial)**
6. I consent to the taking of pictures, videotapes or other electronic reproductions of the patient's medical or surgical condition or treatment, and the use of the pictures, videotapes or electronic reproductions, for treatment or internal or external activities consistent with the Hospital's mission, such as education and research, conducted in accordance with Hospital policies.

7. I authorize the following practitioner(s) (**NAME OF PRACTITIONER** performing procedure):

_____

_____

to perform the following **OPERATION OR PROCEDURE:** ***[Spell out all words, do not abbreviate and identify side/level of procedure to be performed upon if applicable]:*** _____

_____

Additional comments, addendums to consent:_____

_____

_____

_____ _____ _____

Date Time SIGNATURE (Patient, Parent or Properly Designated Representative)

_____ _____

PRINT NAME OF SIGNATOR RELATIONSHIP to Patient

If this document was translated:

_____ or _____ _____ _____ _____

SIGNATURE of interpreter Interpreter ID Vendor Date Time

Language_____

INFORMED CONSENT ATTESTATION:

I have discussed the procedure described above, including the risks, benefits and alternatives with the patient/properly designated representative. I have also explained that with any procedure there is always the possibility of an unexpected complication, and no guarantees or promises can be made concerning the results of any procedure or treatment.

❑ The patient may require blood or blood product transfusion during this operation or procedure and throughout the hospitalization. I have provided the patient/properly designated representative with the pamphlet "A Patient's Guide to Blood Transfusions" concerning the advantages, disadvantages, risks and benefits of autologous blood and/or direct and non-directed homologous blood from volunteers. I have allowed adequate time for the patient to arrange for pre-donation of blood for transfusion purposes, except where there is a life threatening emergency, there are medical contraindications or the patient/properly designated representative has waived this right.

❑ The pamphlet "A Patient's Guide to Blood Transfusions" was not given to the patient/properly designated representative and consent was not obtained for the blood transfusion because a life threatening emergency existed, a properly designated representative was not available to provide consent, and the patient/properly designated representative's wishes with respect to blood transfusion were not known prior to the need for blood transfusion.

❑ Blood or blood product transfusion is not anticipated to be used during the procedure.

All questions were answered and the patient/properly designated representative consents to the procedure.

_____ _____ _____ _____

Date Time Signature and Title of Practitioner Pager #

❑ Telephone Consent Obtained by Practitioner above

2nd Witness **Signature** to Telephone Consent _____

Print Name and Title of 2nd Witness to Telephone Consent _____