CONSENT FOR SURGERY OR OTHER INVASIVE PROCEDURAL TREATMENT

1. PROCEDURE: [Patient’s name], give consent to the following procedure(s):
   [Description of procedure(s)].
   
   My practitioner has discussed with me and I understand what will be involved with my procedure including the fact that I may receive either anesthesia or sedation, or both. I understand my rights and responsibilities to make decisions about my healthcare. I may have received additional education material. I have made my decision voluntarily and freely.

2. RISKS: My practitioner has discussed with me specific risks associated with this procedure. These risks may require additional procedures. I understand that the common risks with any procedure include: stroke, device failure, infection, nerve injury, blood clots, heart attack, allergic reactions, respiratory failure, kidney failure, bleeding, and severe blood loss. These risks can be serious and possibly fatal. I understand and freely assume these risks. Risks and side effects associated with anesthesia or sedation will be discussed with me before I have my procedure. I may be asked to sign a separate consent regarding anesthesia or sedation prior to my procedure.

3. ALTERNATIVES: Reasonable alternative(s) to this procedure have been explained to me by my practitioner. He or she discussed the risks and benefits of not having the procedure. Knowing this information, I choose to have the procedure(s) described on this form.

4. BENEFITS: My practitioner has discussed with me the possible benefits associated with this procedure. I understand that there is no certainty that I will achieve these benefits. No guarantee(s) have/has been made to me regarding the outcome of this procedure.

5. CARE TEAM: I authorize my practitioner, [Practitioner’s name], to perform this procedure. I accept that he or she will be assisted by a care team. My practitioner may include other doctors, doctors in training (“Residents”) or physician assistants to perform and/or assist with part or all of my procedure(s). My care team may include anesthesia providers, nurses, technicians, and medical device specialists.

6. OBSERVERS: My practitioner may allow observers during my procedure. They are not part of the care team and will not participate.

7. BLOOD TRANSFUSION: My practitioner has explained that blood or blood products may need to be used. I understand the side effects and risks, including: allergic reactions, fever, hives, lung injury, and in rare cases, infectious diseases, such as hepatitis and HIV/AIDS. My practitioner discussed with me strategies to reduce the need for blood transfusion including anemia management and blood conservation techniques.

   **(Patient’s initials)** **I DO NOT consent for blood transfusion. Requires signed documents.**

8. PATHOLOGY: I accept that any specimens, such as tissue, blood, bodily fluids, etc. will be examined, disposed of or stored for future use in medical studies or research. Any research involving specimens will be reviewed by an appropriate review board. I understand that my tissue or other explanted material will not be returned to me. Requests for exceptions will be reviewed on a case-by-case basis.

9. VIDEO or PHOTOGRAPHY RECORD: I understand video or photography records made as part of my treatment and/or diagnosis may be useful for clinical education or professional publications. If used in this way, I understand that my records will be edited so that I will not be identified (referred to as “de-identified”). Video or photography records will not be used for any other purpose without my authorization.

   **(Patient’s initials)** I DO NOT authorize my de-identified video or photography records to be used for clinical education or professional publications.

Any questions I have had regarding this procedure have been answered to my satisfaction. By signing below, I attest to my consent to this procedure.

DATE ________________  TIME ________________

Signature (Patient or Legal Representative)        Print Name        Relationship (If other than Patient)

PRACTITIONER’S STATEMENT

I have explained the contents of this document to the patient/legal representative and have answered all the patient’s questions, and to the best of my knowledge, I feel this patient has been adequately informed and has consented.

Practitioner’s Signature           Print Name           DATE ________________  TIME ________________

☐ Yes – Interpreter was used as part of this process.

Qualified Interpreter’s Name / ID#           Language

PATIENT LABEL

SWEDISH

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