E C O N S

Rev. 07/16 50230C298

CONSENT FOR SURGERY OR PROCEDURE

- Please **read** the form
- **Ask** about any part you do not understand.
- **Be sure** you have your questions answered before you sign this form.
- When you **sign it**, you are giving us permission to do this surgery or procedure.

I, _____ (patient's name) agree for Dr. _____ along with any assistants the provider may choose, to do this surgery or procedure on me at _____ (facility):

_____

_____

Name of surgery or name of procedure in medical words – including left, right or level
(health care worker fills this out)

_____

Name of Surgery or name of procedure in my own words
(What the patient or family says back to the health care worker – quote patient or family)

1. I understand that my provider may find other medical problems he/she did not expect during my surgery or procedure. I agree that my provider may do any extra treatments or procedures he/she thinks are needed for medical reasons during my surgery or procedure.

2. I understand that I may be given medicine to put me to sleep, make parts of my body numb or help control pain. Professionals with special training will give this medicine. They may be an anesthesiologist, a nurse anesthetist (CRNA), a nurse, or the doctor doing my surgery or procedure.

3. I understand the provider may remove tissue or body parts during this surgery or procedure. If it is not used for lab studies or teaching, it will be disposed of, as the law requires.

4. I understand that I may be given a substance during an x-ray to make my body tissue easier to see.

5. I understand pictures or video of my surgery or procedure may be taken, if my provider thinks it is needed for medical reasons.

6. I understand someone may watch or help with my surgery or procedure for medical teaching. They are usually medical or nursing students. A technical advisor may watch if my provider thinks one is needed.

7. I understand that **if my provider thinks I need blood** for medical reasons, **it will be given.**

I understand and my provider has told me:

- What I am having done.
- Why I need this surgery or procedure.
- The possible risks to me of having this done.
- The chances of reaching my goals.
- Potential problems that may happen during my recovery.
- What other choices I can make instead of having this done.
- What can happen to me if I chose to do something else.
- What can happen to me if I choose no treatment.
- That there is no guarantee of the results.

Be sure you have your questions answered **before** you sign this form.

I give my permission for this surgery or procedure:

Sign here → _____
Patient's Signature

_____ _____
Date Time

Sign here → _____
Witness Signature

_____ _____
Date Time

This Section is for a Patient who is a minor, or is not legally able to sign. Signature is from a person who has legal rights to consent for the Patient.

Sign Here→ _____
Signature of Person

_____
Legal Consent Relationship

_____ _____
Date Time

Sign here → _____
Witness Signature

_____ _____
Date Time

Telephone Consent

This section is for the witness to confirm the consent discussion is with a person who has legal rights to consent for the Patient.

- The signature only represents a person with legal rights to consent was on the phone.

Name of Person Giving Consent _____ Relationship to Patient _____

Sign Here → _____ _____ _____
Witness Signature Date Time

Sign Here → _____ _____ _____
Witness Signature Date Time

Time Out Verification for Procedures

Time Out Verification:

Name of Procedure: _____

___Correct Patient

___Correct Procedure

___Correct Site/Side

___Correct Positioning

___Correct Supplies/Equipment (Sp02, BP, etc.)/Medication verified with second provider

___Skin Prep Dry

List all persons present at time out (Physician/provider doing procedure must be present during time out.):

_____

_____

_____

_____

_____

Staff Signature: _____

Date: _____ Time: _____

Patient Label

E O P R

PERIOPERATIVE DEVICE MANAGEMENT

Date: _____ Time: _____

Patient Name _____

Planned Procedure _____ Location: ☐ Above Umbilicus ☐ Below Umbilicus

Cardiologist _____ Office # _____

Home Device Y _____ or N _____ Will bring Home Device Y _____ or N _____

Device Company_____ Model _____

Rep. Notified: Y _____ or N _____

Device Type:

Pacer _____ ICD _____

Document any additional information below that patient is able to answer:

Indication for Device _____

Date of Last Interrogation _____

Programming of Device

Pacer Mode Y _____ or N _____ Programmed Rate _____

(Interrogation Within last 12 months)

ICD Therapy

Lowest Heart Rate for Shock _____

Lowest Heart Rate for ATP Delivery _____

Is Patient Pacemaker Dependent Y _____ N _____

What is Underlying Rhythm _____

Patient Label