



(Stamp patient nameplate here)

INFORMED CONSENT TO SURGICAL OR DIAGNOSTIC PROCEDURE

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

Name of Patient: _____ Date of Birth: ____/____/____

(A)(I) I acknowledge and understand that the following procedure(s) which has (have) been described to me is (are) to be performed on the patient at Saint Joseph's Hospital of Atlanta, Saint Joseph's Mercy Care or an affiliate facility:

Name of Procedure(s): _____

Purpose/Indications for Procedure(s): _____

Material Risks of The Procedure(s):

I understand the practice of medicine is not an exact science and acknowledge I have not received any guarantees, assurances, or promises concerning the results of the procedure(s). All medical procedures have some risks, including risks that are likely but not severe and severe but not likely. I understand it is not possible to list every risk for every procedure used in modern health care and the following list of material risks does not include every possible risk. I understand as a result of the performance of the procedure(s) there is a material risk the patient may suffer infection, allergic reaction, severe loss of blood, loss or loss of function of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, disfiguring scar, brain damage, cardiac arrest (heart attack), or death.

Transfusion of Blood or Blood Products (Please read and check ONE of the boxes below): During the patient's care, the patient may need to receive a transfusion of blood and/or a blood product into a vein, commonly the arm. It may consist of red blood cells, platelets, coagulation factor, plasma or some other blood product. Risks can include slight bruising, swelling or local inflammation, slight headache, fever or a mild skin reaction (such as itching or rash). A serious reaction, including death, to the transfused blood or blood product is possible although unlikely. Despite screening, the possibility exists for infections to be transmitted through donated blood, including but not limited to hepatitis, HIV, human T-cell lymphoma/leukemia virus, syphilis, and cytomegalovirus. *I understand the administration of any transfusion(s) is a service rather than the sale of a product or good governed by the Uniform Commercial Code.*

____ Initial I authorize the physician to request and use blood transfusions as he/she deems necessary

OR

____ Initial I DO NOT WANT AND THEREFORE REFUSE any transfusion(s) of blood or blood product(s). *I release Saint Joseph's Hospital of Atlanta, its affiliates, and their officers, directors, medical staff, agents and employees from any and all claims or damages arising from or relating to this refusal.* I understand that I may be asked to sign an additional form regarding this refusal.

Risks of Procedural Sedation, Anesthesia and/or Contrast Media: I understand the procedure(s) may involve anesthesia or intravenous ("IV") procedural sedation services and/or the intravenous or intraductal injection of a contrast material. Anesthesia and/or procedural sedation, which would be provided by: _____ (insert name of physician and physician group ordering anesthesia, intravenous procedural sedation or contrast media);



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may include:

(i) monitoring of vital signs; (ii) regional anesthesia (including spinal and epidural anesthesia); (iii) general anesthesia; and (iv) some forms of pain management (including epidural). I understand it may be necessary to proceed from local, regional, and/or procedural sedation to general anesthesia during the procedure. I understand that if the procedure requires certain types of planned anesthesia, an anesthesiologist will discuss these risks with the Patient and obtain the Patient’s separate informed consent to anesthesia prior to procedure. I understand the risks of procedural sedation and anesthesia may include, but are not limited to: those risks listed above as Material Risks, as well as injury to or miscarriage of unborn child, stroke, temporary or permanent injury to nerves (including persistent pain, loss of feeling and ability to move), reaction to the anesthetic drug, headache, seizure, dental or eye injury, pneumonia related to vomiting, injury to lung or blood vessels with loss of circulation, esophageal tear, oversedation, breathing problems, and death. If the procedure involves contrast media, this means contrast material (or dye) is used to make specific organs, blood vessels, ducts or types of tissue more visible, such as on an X-ray, CT scan, ultrasound or MRI scan. Common contrast material substances include, but are not limited to, iodine, barium, and gadolinium, and risks can include minor reactions (itching, rash or an upset stomach) or possibly serious reactions (such as shortness of breath, irregular heartbeat, convulsions, adverse effects to kidney and renal status, including kidney failure, unconsciousness, or death). **If the Patient has ever had a severe allergic reaction to ANY substance or environment (including latex or a bee sting), it is his/her responsibility to notify the attending physician and/or anesthesiologist before medication or other substances are given.**

(A)(2) Consent To Other Treatment: I acknowledge and understand that during the course of the procedure(s) described in subparagraph (A)(1) above, conditions may develop which may reasonably necessitate an extension of the original procedure(s) or the performance of procedure(s) which are unforeseen or not known to be needed at the time this consent is obtained. I therefore specifically consent to and authorize the persons described in paragraph D, below, of this consent to make the decisions concerning the performance of and to perform such procedure(s) as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures, including those conditions which may be unknown or unforeseen at the time this consent is obtained.

(B) Description of Consent Information: I, as the patient or the patient’s authorized representative, acknowledge, understand, and confirm by signing this form that I have been informed by the responsible physician or his or her designee, in general terms of the following information, which is sufficient to enable me to decide whether to consent to the procedure(s):

- (1) The patient’s health status, prognosis, and diagnosis of the condition requiring the procedure(s);
- (2) The nature and purpose of the procedure(s), including potential anticipated benefits;
- (3) The material risks of the procedure(s) (see paragraph (A)(1) above);
- (4) The likelihood of achieving goals and success of the procedure(s);
- (5) The practical, reasonable alternatives to such procedure(s);
- (6) The prognosis if the procedure(s) is (are) rejected;
- (7) The relevant risks, benefits, and side effects related to the alternatives, including the possible results of declining the recommended care, treatment and services;
- (8) Potential problems that might occur during recuperation;
- (9) When indicated, any limitations on the confidentiality of information learned from or about the Patient; and

The following procedure-specific information or materials, if any (**please initial on right side**):

_____ Initial of Patient/Authorized Representative: _____

_____ Initial of Patient/Authorized Representative: _____

_____ Initial of Patient/Authorized Representative: _____

(Stamp patient nameplate here)

and such was provided through the use of video tapes, audio tapes, pamphlets, booklets, or other means of communication or through conversations with the responsible physician, or other medical personnel under the supervision and control of the responsible physician, other medical personnel involved in the course of treatment, nurses, physician's assistants. I understand that patients may have certain rights as to confidentiality, safety and privacy, and I can ask the physician if I have questions about such rights, the procedures or this form. I understand and agree that my procedure(s) may be photographed or recorded by SJHA for internal purposes. I also understand and agree my procedure(s) can be observed by students, manufacturing or company representatives, and/or other health care providers for purposes of research, education, training or other informational purposes, unless I OPT OUT BY INITIALING HERE: _____.

(C) Alternatives: I acknowledge that there are practical alternatives to the procedure(s) described in paragraph (A) which alternative reasonably prudent physicians generally recognize and accept.

(D) Other Health Care Personnel: I acknowledge and understand this request for and consent to surgical or diagnostic services is valid for the responsible physician, all medical personnel under the direct supervision and control of the responsible physician, and for all other medical personnel otherwise involved in the course of treatment. I understand physicians other than the operating practitioner, including but not limited to residents, physicians receiving additional training or qualified medical practitioners who are not physicians, will be performing important tasks or parts of the surgery or anesthesia, in accordance with Hospital policies, within their scope of practice, as permitted by State law, based on their skill set, under supervision and/or for which they have been granted privileges by the Hospital. I understand some or all of the health care 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 contractor.

(E) Pregnancy Testing: If the Patient is female *and unless I opt out below*, I request and consent to the Hospital performing a blood pregnancy test, as part of the Hospital's routine pre-operative lab work due to the possible risks of anesthesia and certain medications on an unborn fetus, including birth defects and miscarriage. I understand a blood pregnancy test is generally accurate, but no pregnancy test is 100% reliable, and there is a possibility this test could miss an early pregnancy or have a false positive result. **If the Patient believes she might be pregnant, it is her responsibility to notify her attending physician and anesthesiologist before any medication or anesthesia is given.**

_____ **Initial I refuse a pregnancy test and voluntarily assume the risk of any injury or damage to me and my unborn child if I am pregnant.**

(F) If a Physician Has Signed and issued DNR (Do Not Resuscitate) Order For You:

If you wish to have the physician temporarily cancel the DNR order (so you will be resuscitated), please read and initial:

If I have consented to a do not resuscitate order, **I TEMPORARILY REVOKE (CANCEL) my consent to a DNR order and ask that the physician temporarily cancel any such do not resuscitate orders** while I undergo any elective, invasive, interventional and/or operative procedure performed at this Hospital, whether inpatient or outpatient. **I WANT TO BE RESUSCITATED.** This temporary revocation (cancellation) of a DNR order should remain in effect until I leave the recovery area after such procedures. It is my desire for all such previous do not resuscitate orders to be re-instated (be put back in effect) after I leave the recovery area after the procedure's completion.

Initials of Patient or Patient's Representative: _____ **Date:** _____ **Time:** _____
OR

(Stamp patient nameplate here)

If you do NOT want to cancel, but instead want to keep the DNR order in effect (so you will NOT be resuscitated), please read and initial:

If I have consented to a do not resuscitate order, **I confirm that I STILL WANT the do not resuscitate order in effect** while I undergo any elective, invasive, interventional and operative procedures performed at this Hospital, whether inpatient or outpatient. ***I DO NOT WANT TO BE RESUSCITATED.***

Initials of Patient or Patient's Representative: _____ Date: _____ Time: _____.

(G) Certification and Signatures:

I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS, AND ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ THIS FORM OR HAD THIS FORM READ AND/OR EXPLAINED TO ME AND THAT I FULLY UNDERSTAND THIS FORM AND I VOLUNTARILY CONSENT TO ALLOW THE RESPONSIBLE PHYSICIAN, DR. _____, OR ANY PHYSICIAN DESIGNATED OR SELECTED BY HIM OR HER AND ALL MEDICAL PERSONNEL UNDER THE DIRECT SUPERVISION AND CONTROL OF SUCH PHYSICIAN AND ALL OTHER PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN PERFORMING SUCH PROCEDURES, TO PERFORM THE PROCEDURES DESCRIBED OR REFERRED TO HEREIN. [Note to SJHA: if residents will be performing important part of surgery (as defined by CMS) at SJHA during their residency training program, additional information is required.]

Signature of Patient or Authorized Representative

Date

Time

If Signed by Person on Behalf of Patient, Print Name and Relationship to Patient

Signature of Witness (certifying present when form signed; can be adult family member, responsible adult present in room, or Hospital agent/employee present during signing)

Date

Time

Signature of Responsible Physician

Date

Time