CONORA

THE UNIVERSITY HOSPITAL
AUTHORITY FOR TREATMENT
CONSENT TO OPERATION OR OTHER
INVASIVE PROCEDURE ADMINISTRATION
OF ANESTHETICS AND RENDERING
OF OTHER MEDICAL SERVICES

PATIENT NAME: _____

TUH-103, Rev. 11/07 **Chart Place: Adm. & Consent Form Tab**

I authorize _____ (lead practitioner/surgeon performing the procedure) and the associates or assistants of his/her choice to treat the following condition(s) (pre procedure diagnosis):

_____

_____

My physician/practitioner _____ has explained the procedure necessary to treat my condition as follows: _____

_____

_____

_____

Procedure Site (check all that apply:) ☐ Right side ☐ Left side ☐ Neither ☐ Multiple sites (describe) or multiple structures (fingers, toes), or levels (spine): _____

_____

I understand that possible risks such as severe blood loss, infection, nerve damage, cardiac arrest and even death, among others, may occur in any surgical procedure. My physician has explained the material risks and benefits associated with this procedure and potential problems that might occur during recuperation. Additional risks include:

_____

_____

(optional description of additional risks) or ☐ supplemental page attached

My physician has discussed appropriate alternatives and their associated benefits and risks. This includes the possible results from not receiving the recommended care, treatment, and services.

The likelihood of achieving the goals of this procedure is: ☐ Poor ☐ Fair ☐ Good ☐ Unknown due to:

_____

I understand that during the course of the operation, unforeseen conditions may become apparent which require an extension of the original procedure, an additional procedure or a different procedure. I authorize my practitioner, his/her associates or assistants to perform such procedures, as they, in the exercise of their professional judgment, deem necessary and advisable.

I consent to the administration of anesthetics. I understand that an anesthesiologist will direct my anesthesia care unless an anesthesiologist is not required because of the type of procedure or the medication to be used. I understand the nature of the proposed anesthesia, as well as any risks, benefits and alternatives. Risks of anesthesia include but are not limited to: sore throat; hoarseness; injury to face, mouth or teeth; nausea; headache; injury to blood vessels or nerves; brain damage, paralysis, or death.

I understand that physicians and other practitioners in addition to the lead practitioner/surgeon may be involved in my treatment, including Resident physicians and other trainees. They may perform such tasks only within their scope of practice and license, and as set forth in the privileges granted by the hospital. Residents may participate under the oversight of the Attending physician/surgeon, depending on their level of education and skills, and the patient's condition. The names of these individuals will be identified in the operative record.

I consent to the transfusion of blood or blood products from a community donor pool and as may be available from other sources arranged by my practitioner. I understand that there are potential risks and side effects from blood transfusions, though rare, and that some of these include transfusion reaction, viral hepatitis and HIV infection.

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I understand that my Advance Directive will be suspended during, and up to 24 hours after, an operative or high-risk procedure. (Please speak with your physician if you have any issues with this.)

The University Hospital is dedicated to advancing medical knowledge to improve care for its patients. I understand that the procedures outlined below are necessary to support this mission and I consent to them. **However, I may cross out either or both procedures if I do not consent and it will not affect my care.**

I consent to the photographing or televising of the operation or procedure to be performed, including appropriate portions of my/the patient's body, for medical, scientific or educational purposes as long as my/the patient's identity is not disclosed. I understand that: 1) if I am conscious during a procedure, I can ask that the recording stop and 2) I can rescind (take back) my consent for use of this media up to a reasonable time before the images are used.

All specimens or tissues removed from my body that would otherwise be disposed of may be used for genetic and other research, or for scientific or educational purposes as approved by the Institutional Review Board of the University of Cincinnati Academic Health Center. No one except specifically authorized persons will have access to the tissue samples or information derived from my medical records. Every reasonable effort will be made to maintain confidentiality.

Additional comments:

_____

All information concerning this procedure and necessary for my informed consent, including alternative or no treatment has been disclosed to me. Also, all my questions about the procedure, including the expected involvement of other practitioners and trainees, have been answered.

I understand 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 this procedure.

I explained the risks, benefits and alternatives of this procedure, including the above, with the patient, or the patient's representative (Physician or other individual practitioner)

_____
(Physician's/Credentialed Provider's Signature) **(Printed Name)** **(Date and Time)**

I give my permission and consent to the treatment or procedure specified above:

_____
(Patient's Signature) **(Printed Name)** **(Date and Time)**

Patient is unable to consent. I therefore consent for this patient.

_____
(Signature of Surrogate Decision-maker) (Printed Name/Relationship) (Date and Time)

_____
(Signature of Witness if consent by telephone or otherwise not obtained at the time of the initial explanation)
(Printed Name) (Date and Time)

☐ Check if telephone consent ☐ Check if interpreter involved _____ (Name)