MUNSON HEALTHCARE

0303

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be performed, so that you may make a decision to undergo the procedure with knowledge of the risks and benefits. This disclosure of possible risks is not meant to scare or alarm you; it is simply an effort to make you better informed so you can give, or withhold, your consent for the proposed procedure.

The procedure, treatment, or therapy is:

I consent to the performance of the procedure named above, by _____
Physician / Provider Name

I know that my doctor may ask other healthcare providers to help with the procedure, which may include other physicians, or a Certified Surgical Assistant, Physician Assistant, Nurse Practitioner, or RN/Certified First Assistant. I understand that resident physicians, healthcare professionals, and healthcare students may be present to observe or assist my doctor in performing the procedure. My doctor may ask a representative of a healthcare device company to be present for consultation.

I understand:

- The general purpose and reason for the operation, procedure, or treatment
- Other treatment options and the benefits of this operation, procedure, or treatment
- The potential risks, complications, and inconveniences of this operation, procedure or treatment
- What could happen to me without this operation, procedure, or treatment
- My chances of a good result

I understand that no warranty or guarantee has or can be made to me as to a certain result or cure. Although all procedures differ, common risks associated with almost any procedure include infection, bleeding, damage to organs, heart or lung complications, and even death. I know unforeseen events and complications other than those discussed with me may occur, and I could be in the hospital, sick or disabled, much longer than anyone expects. I know that it is up to me to tell the doctors about allergies I have, drugs or medicines I have taken, and any other health problems I have.

If during this procedure, the doctor(s) find it necessary to perform additional and/or different procedures than those listed above, which are not known to be needed at the time this consent is given, I consent to the performance of such procedures.

I agree that tissues or organs taken from my body may be tested or kept for the purpose of research or teaching. I agree the hospital may discard these in a proper way.

PATIENT ID LABEL HERE

CONFIRMATION OF INFORMED CONSENT

I agree that any photographs, x-rays, or video recordings, if taken, may be included in my medical record or may be used for teaching purposes with my identity protected.

Anesthesia / Sedation: I understand that receiving anesthesia and sedation also involves risks, but request their use for the relief of, and protection from, pain during the procedure. I understand that if the involvement of an anesthesiologist or certified nurse anesthetist is deemed necessary to safely accomplish this, that person will discuss the planned anesthetic with me prior to the procedure, in order that I may be informed and agree to the plan before I proceed with the surgery.

Medical Implants / Explants: If applicable to my procedure, I agree to the release of my name, address, date of birth, and Social Security number, to the company that makes the medical device that is put in or removed during this procedure. Federal laws and rules require this. The company will use this information to locate me, if needed.

Blood Transfusion: I understand that in the event of severe blood loss, I may require transfusion of blood products. There are risks with blood transfusions, including but not limited to: Break down of red blood cells, fluid in the lungs, fever, chills, allergic reaction, infection such as hepatitis, HIV (AIDS). I know that in an emergency, I may need blood products before all laboratory tests are done.

Other Risks / Benefits:

By signing this form, I agree:

- **I have read this form, or had it read and explained to me**
- **I fully understand its contents**
- **I have been given time to ask questions and I have had my questions answered satisfactorily**
- **I have talked with my doctor or other healthcare staff in words I can understand**
- **I want to consent to the procedure/treatment described above**

Signature of Patient / Guardian / Legal Representative	Date	Time
Witness Signature	Date	Time

PATIENT ID LABEL HERE

CONFIRMATION OF INFORMED CONSENT