Informed Consent for Operative / Invasive Procedure CP2.10

Date ________  Time ________

I, the undersigned, consent to the following operation(s) and / or procedure(s): **CT- and/or ultrasound-guided percutaneous needle biopsy**

______________________________
Dr. __________________________
and his / her associates and assistants (including resident physicians), with knowledge that the attending physician will have primary responsibility for my care specific to the stated procedure. Dr. __________________________ has explained to me the nature and purpose of each operation(s) and / or procedure(s) as well as the substantial risks and possible complications involved, the benefits and the medically reasonable alternative methods of treatment.

The **SUBSTANTIAL RISKS** include but are not limited to: (check if applicable and add additional risks as indicated):

☑ perforation and / or injury to adjacent blood vessels, nerves and / or organs
☑ bleeding
☑ infection

allergic reaction to local anesthetic ("numbing medication") and / or antiseptic/antibacterial solution; allergic reaction to contrast medium; pneumothorax (collapsed lung) – requiring possible chest tube placement; emergent surgery; death

The **POTENTIAL BENEFIT(S)** include but are not limited to: determination of tissue type/pathology and/or causative organism

The **MEDICALLY REASONABLE ALTERNATIVE(S)** options are: surgery; observation

- I understand and consent to Shands’ disposing of any tissue, parts or organs that are removed during the operation(s) and / or procedure(s), in accordance with its usual practice.
- I understand that the information I have received, about risks is not exhaustive and there may be other, more remote risks.
- I have had the opportunity to ask questions regarding the proposed procedure(s) and all my questions have been answered to my satisfaction.
- I have read or have had read to me, this Operative / Invasive Procedure Informed Consent form.
- I have had explained to me, and I understand the potential benefits and drawbacks, potential problems related to recuperation, the likelihood of success, the possible results of non-treatment, and any medically reasonable alternatives.
- I have received no guarantees from anyone regarding the results that may be obtained.
- I know the relationship, if any, of my physician or other practitioner, to any teaching facility involved in my care.

Operative / Invasive Procedure Informed Consent (page 1 of 2)
My initials below indicate whether or not I consent to additional operations and / or procedures as are considered diagnostically or therapeutically necessary.

______ I consent OR
______ I do not consent

to additional operations and / or procedures as are considered diagnostically or therapeutically necessary on the basis of findings during the course of the operation(s) and / or procedure(s) described above and I accept the risks that may be associated with such additional operation(s) and / or procedure(s).

My initials below indicate whether observers may be present during my procedure, in accordance with my physicians' approval and hospital policy.

______ I give permission to allow observers in the room during my procedure.
______ I do not give permission to allow observers in the room during my procedure.

CONSENT

I do hereby consent to the above described operation(s) and / or procedure(s).

Date _______

Patient Signature __________________________ Patient Printed Name __________________________

Witness Signature __________________________ Witness Printed Name __________________________

SIGNATURES FOR CONSENT WHEN GIVEN BY REPRESENTATIVE OF PATIENT

If patient is unable to consent, complete the following:

☐ Patient is a minor, or
☐ Patient is unable to consent because: __________________________________________

Date _______

Patient's Name __________________________________________

Representative's Signature __________________________

Representative's Printed Name __________________________ Relationship to Patient __________________________

Witness Signature __________________________ Witness Printed Name __________________________

SIGNATURES OF PHYSICIAN WHO OBTAINED CONSENT

I certify that the procedure(s) described above, including the substantial risks, benefits, possible complications, anticipated results, alternative treatment options, including non-treatment, the likelihood of success and the possible problems related to recuperation, were explained by me to the patient or his / her legal representative.

Date _______ Signature of Physician Who Obtained Consent __________________________

Physician Identification Number __________________________

Operative / Invasive Procedure Informed Consent (page 2 of 2)
If printed electronically, pages 1 & 2 must be stapled.

Rev. 5/2/05
Informed Consent for Sedation During Procedures CP2.22

Date _____  Time _____

1. I, the undersigned, consent to the following:
   - Administration of IV sedation
   - Administration of IV sedation with dissociative medication
   - Other: chloral hydrate

I consent to the above sedation to be performed by Dr. ____________________________ and associates and assistants of the doctor's choice with knowledge that Dr. ____________________________ will have primary responsibility for my care specific to the stated sedation.

2. Dr. ____________________________ has explained to me the nature, purpose and possible consequences of sedation as well as the substantial risks and possible complications involved, the benefits and the possible alternative methods of treatment.

The SUBSTANTIAL RISKS include but are not limited to: Nausea / vomiting; aspiration; disorientation; prolonged unconsciousness or drowsiness; problems with breathing; staggering / unsteady gait or balance; slow reflexes; confusion; irritability; paradoxical effect (unusual excitement); dizziness; hallucinations or nightmares; death

Rare Side Effects: difficulty breathing; aspiration; shortness of breath; fever; chills; sore throat; irregular heartbeat; low blood pressure; skin rash; itching; allergic reaction; tremors; diarrhea; extreme irritability; stomach upset

The POTENTIAL BENEFITS include but are not limited to: The administration of sedation allows you to undergo the procedure with minimal or no discomfort; reduces anxiety; allows for diagnostic exam to be performed

The MEDICALLY REASONABLE ALTERNATIVE options are: anesthesia
I understand that the explanation I have received, as well as the lists above, are not exhaustive and there may be other, more remote risks.

I have had the opportunity to ask any questions I have regarding the proposed sedation and my questions have been answered to my satisfaction.

I have read or have had read to me, this Informed Consent for Sedation form.

I have had explained to me, and I understand the potential benefits, potential problems related to recuperation, the likelihood of success, the possible results of non-treatment, and any significant alternatives. I have received no guarantees from anyone of the results that may be obtained.

I know the relationship, if any, of my physician or other practitioner, to any teaching facility involved in my care.

My initials below indicate whether or not I consent to additional sedation procedures as are considered therapeutically necessary.

[ ] I consent
[ ] I do not consent

to additional sedation procedures as are considered therapeutically necessary on the basis of findings during the course of the operation(s) and / or procedure(s) described above and I accept the risks that may be associated with my decision.

CONSENT

I do hereby consent to the above described sedation.

Date ______

Patient’s Name ________________________________________

Patient’s Signature ______________________________________

Witness Signature ________________________________ Witness Printed Name ________________________________

If patient is unable to consent, complete the following:
[ ] Patient is a minor, or
[ ] Patient is unable to consent because: ____________________________________________________________

Date ______

Patient’s Name ________________________________________

Representative’s Signature ______________________________________

Representative’s Printed Name __________________________ Relationship to Patient __________________________

Witness Signature ________________________________ Witness Printed Name ________________________________

SIGNATURES OF PHYSICIAN WHO OBTAINED CONSENT

I certify that the sedation procedure(s) described above, including the substantial risks, benefits, possible complications, anticipated results, alternative treatment options, including non-treatment, the likelihood of success and the possible problems related to recuperation, have been explained by me to the patient or his / her legal representative before the patient of his / her legal representative consented to the sedation.

Date ______ Signature of Physician Who Obtained Consent ________________________________

Physician Identification Number ________________________________