

SHANDS HealthCare

Facility: Shands at UF
please print facility name

This form provided by Shands at UF as a courtesy to patients and their physicians

Patient Name: _____

MR#: _____

Informed Consent for Operative / Invasive Procedure CP2.10

Date _____ Time _____

I, the undersigned, consent to the following operation(s) and / or procedure(s); **percutaneous placement of gastrostomy or gastrojejunostomy tube (feeding tube)**_____

to be performed by 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

contrast medium (if administered); cellulitis and / or peritonitis; emergency surgery; failure of tube to be placed _____

The **POTENTIAL BENEFIT(S)** include but are not limited to: providing access for nutritional support, medication administration, and / or decompression of the stomach _____

The **MEDICALLY REASONABLE ALTERNATIVE(s)** options are: surgical placement; endoscopic placement; nasogastric feeding tube; IV hydration; total parenteral nutrition; or 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.

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 _____

SHANDS HealthCare

Facility: Shands at UF
please print facility name

This form provided by Shands at UF as a courtesy to patients and their physicians

Patient Name: _____

MR#: _____

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 or his / her legal representative consented to the sedation.

Date _____ Signature of Physician Who Obtained Consent _____
 Physician Identification Number _____