Informed Consent Surgical and Other Procedures With Sedation

**To the Patient or Person Legally Responsible for Patient:**
You have the right as a patient to be informed about your condition and the recommended surgical, medical, or diagnostic procedures to be performed so that you may make an informed decision as to whether or not to undergo the procedure after knowing the risks, benefits and alternatives. This disclosure is an effort to inform you so that you may give or withhold your consent to the procedure at any time prior to its performance.

**Planned Procedure Is:**

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**Request and Consent for Treatment:**
I voluntarily request
Dr. __________ as my physician and such associates, students, technical assistants, and other health care providers as my physician may deem necessary, to perform the planned procedure which has been explained to me as:

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☐ (If checked, a more detailed description of the procedures is attached to this form.)

I understand that my physician may discover other or different conditions which require additional and/or different procedures than those planned, including emergency administration of blood or a blood derivative. I authorize my physician and such associates, students, technical assistants and other health care providers to perform such other procedures, including emergency administration of blood or a blood derivative, which are advisable in their professional judgments.

**Laser Surgery:**
I understand that if this procedure is performed by laser, a further risk of burns to other organs, burns to the eyes or superficial burns to skin/tissue could occur.

**Disposal of Tissue:**
The hospital pathologist is hereby authorized to use his/her discretion in disposing of any member, organ or other tissue removed from my person during the procedure(s) performed.

**No Guarantee:**
I understand that no warranty or guarantee has been made to me as to the result of the medical treatment or services rendered to me or the cure of my medical conditions.

**Benefits:**
The benefit of the procedure is:

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**Risks:**
Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards with medical and/or diagnostic procedures planned for me. I realize that risks common to surgical and medical procedures include: infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death. I also realize that the following risks and hazards may occur in connection with the particular procedure:

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☐ (If checked, a more detailed description of the risks associated with this procedure is attached to this form.)

**Alternatives:**
Alternatives to this procedure are:

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PATIENT LABEL

FORM CONTINUED ON BACK

Page 1 of 2
**Photographs, Observers:**
I consent to the photographing and videotaping of the operations and procedures to be performed and to the presence of students or other observers in the operating room to observe the procedure for the purpose of advancing medical education. I am aware that only my physician may grant this permission on my consent. Any video and/or photographic documentation, if used, would include appropriate portions of my body for medical, scientific, or educational purposes. My identity would not be revealed by descriptive texts accompanying the pictures.

**Consent for Sedation / Analgesia:**
I understand that my physician has recommended administration of Conscious Sedation in conjunction with my invasive/other procedure. I consent to receiving sedation and authorize my physician and Coliseum Northside Hospital to administer the necessary medications.

**Benefits:**
The benefits of conscious sedation include:
- A decreased awareness of the procedure.
- Maintenance of normal vital signs due to decrease in sensation and anxiety.

**Risks:**
I realize that risks common to sedation and analgesia include:
- Decreased ventilation – Breathing may require supportive care, such as mask, oral airway, or intubation.
- Change in vital signs, such as decrease in BP and heart rate.
- Decreased mental ability for several hours after medication.
- Nausea and vomiting.
- Chest tightness.
- Allergic reaction to medication.

**Alternatives:**
An alternative to sedation/analgesia is:
- To not have any medication.

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I have been given a opportunity to ask questions about my conditions, alternative forms of treatment, risks and benefits of the planned procedures and sedation / analgesia, and risk / consequences of non-treatment. These questions have been answered to my satisfaction. I have sufficient information to give this informed consent.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in and that I understand its contents.

---

**DATE**

**PATIENT'S PRINTED NAME**

**X**

**SIGNATURE OF PATIENT**

**PARENT/GUARDIAN/CONSERVATOR/DPOAHC AGENT**

**RELATIONSHIP TO PATIENT**

**SIGNATURE OF WITNESS**

**NAME OF WITNESS TO SIGNATURE**

I certify that the risks and benefits of the procedure(s) listed above, as well as alternative forms of treatment, have been fully explained to the patient and all questions have been answered to the patient's satisfaction.

**DATE**

**TIME**

**PHYSICIAN'S PRINTED NAME**

**SIGNATURE OF PHYSICIAN**