

I _____, authorize the performance of the following
(Name of Patient)
operation/procedure: _____
(State nature and extent of operation)

to be performed by Dr. _____

1. I understand that other practitioners or assistants such as surgical fellows, residents, physician assistants, or nurse practitioners may assist with certain aspects of the surgical procedure under the supervision of my primary surgeon. Assistance may be provided by:
 - Surgical fellow or resident who may assist in procedures, such as opening and closing of surgical wounds, dissecting of tissue, excision of tissue, holding of retractors, harvesting of grafts and implanting devices.
 - Nurse Practitioner or Physician Assistant may assist in procedures such as opening and closing of surgical wounds, cast application, holding of retractors, assisting with surgical equipment, dissection and excision of tissue.
2. I have had explained to me the nature of my condition, the nature of the procedure(s)/treatments, the nature and probability of the material (meaning important) risk involved, the benefits to be reasonably expected compared with the alternative approaches, the approximate recovery time and the likely result of no treatment. I understand that this form is intended to provide a written confirmation of such discussions.
3. I have had explained to me the likelihood of material risks or complications of this procedure/treatment, including (if applicable) but not limited to: allergic reactions, drug reactions, bleeding, blood clots, nerve injury, brain damage, infection and even loss of bodily function or life. I also understand that during the course of the proposed procedure(s)/treatment(s) unforeseen conditions may be encountered requiring the performance of additional procedure(s)/treatment(s) and I authorize the physician named above to use his/her best judgment on my behalf in treating such an event.
4. I am aware that other unexpected risks or complications not discussed may occur and I acknowledge that no guarantees or promises have been made to me concerning the results of any procedure(s) or treatment(s).
5. I also understand that the following particular material risks among others may occur in connection with the procedure(s)/treatment(s) proposed for me: _____

(Record particular risks or attach supplementary text)

6. I consent to the surgical implantation in me of such devices as my doctor and associates may deem advisable, whether or not the use of such instrumentation has been approved by the Food & Drug Administration. I am also aware that if the surgical procedure requires implantation of a medical device/prosthesis or removal thereof, the hospital is required under the Safe Medical Device Act of 1990 to release my name, current address and social security number to the manufacturer for purposes of tracking the device.
7. I understand that if I do not require general anesthesia, I may be given sedation during the treatment. I further understand that while I will remain conscious, there are risks as with any procedure as noted above. At times, even with conscious sedation, it may be necessary to ventilate the lungs of the patient. Additional risks of lung ventilation, which requires the placement of a breathing tube could include: injury to teeth, damage to vocal cords, respiratory problems, and minor pain and discomfort.
8. If the transfusion of blood components is required, I understand that there are risks even when all precautions are taken. These material risks include (but are not limited to): fever, chills, allergic reactions such as hives, heart failure and rarely, destruction of the transfused red blood cells with fever, shock, chest pain, and/or red urine, or the transmission of infectious agents such as bacteria, hepatitis virus, the human immunodeficiency virus (HIV). The risks, benefits and alternatives have been explained to me. I give consent for the use of blood components.



9. If bone tissue is needed during my surgery, I understand that this bone has been donated from other patients and carries the same risks as blood transfusions. I give consent for the use of bone tissue in my surgery.
10. On the condition that my identity remains confidential, I authorize New England Baptist Hospital or its designated agent, to use any information relating to my care to further the treatment of other living persons, medical education and research, or other related purposes. I also authorize the Hospital to preserve, use, photograph and/or dispose of tissue, fluids, and bone, if any, removed from me.
11. On the condition that my identity remains confidential, I authorize the Hospital to preserve, photograph, study or use for research purposes any discarded tissue, bone, or fluids. I understand that this discarded tissue, bone or fluids may ultimately be disposed of. I agree to this participation.
12. I understand that the Hospital or its designated agent may from time to time photograph or videotape a surgical procedure or treatment of particular scientific interest for the advancement of medical care, research and education, unless I expressly request otherwise. In such instances, the identity of the patient remains confidential.
13. New England Baptist Hospital is a teaching facility. Residents, fellows, medical students, nursing students, and other health care professionals in training may, participate in patient care under the supervision of senior staff. I agree to this participation.
14. Individuals who are not healthcare providers, such as health care industry representatives, may be present in the operating room to observe and provide technical support.
- 15. I have had explained to me by my physician any financial or other interest he/she may have in the selection of drugs or devices to be used in my care**
16. I have explained to the patient or patient representative the nature of the patient's condition, the nature of the procedure(s) I am proposing, and the benefits to be reasonably expected compared with alternative approaches. I have discussed the likelihood of the major risks and complications of this procedure. Benefits may include but are not limited to:

(Record particular benefits or attach supplementary text)

Alternatives may included:

(Record particular benefits or attach supplementary text)

Comments:

I acknowledge that I have been given the opportunity to ask questions and all questions were answered to my satisfaction. I understand that I can modify this consent by crossing out any provisions with which I do not agree.

X _____ X _____ X _____
Patient (or person authorized to sign for patient, and relationship) Date Time

I have explained that other unexpected complications not discussed may occur and that no guarantees have been made by me concerning the results of this procedure. I have also explained that during the course of the proposed procedures, unforeseen conditions may be revealed requiring the performance of additional procedures. I believe that the patient or patient representative understands these material risks and complications associated with the planned procedure.

X _____ X _____ X _____
Patient (or person authorized to sign for patient, and relationship) Date Time

