

**CONSENT TO OPERATION, PROCEDURES, BLOOD TRANSFUSION
AND ADMINISTRATION OF ANESTHETICS**

1. I hereby authorize Dr(s). _____, and any associates or assistants as may be selected by him/her to perform the following operation(s) or procedure(s) (this description should include the side and site of the procedure): Blood Transfusion: Intravenous administration of blood products

2. **INDIVIDUALS ASSISTING/PERFORMING PROCEDURE:** I understand that UCDHS is a teaching institution and that the associates or assistants involved in the operation(s) or procedure(s) may include residents, fellows, medical students or other allied healthcare professionals. I authorize that such associates or assistants perform portions of the operation(s) or procedure(s) under the instruction, direction and/or supervision of the physician(s) identified in paragraph 1, above.

3. I understand that Dr(s). _____ will be present during the key portions of the operation(s) or procedure(s) and at all other times will be immediately available or will ensure another qualified surgeon is immediately available.

4. The operation(s) or procedure(s) has been explained to me by _____

5. I have been informed that there are significant risks, such as severe loss of blood, blood clots, infection, cardiac arrest, and other untoward consequences, that are involved in the performance of any surgical procedure that can lead to death or permanent or temporary disability or complete or partial disability. I have been made aware of certain risks and consequences that are associated with the procedure(s) described in paragraph 1. These include but are not limited to: fever, allergic reaction, hemolytic reaction, lung injury, infection (HIV 1 in 2 million, Hepatitis B 1 in 205,000, Hepatitis C 1 in 2 million), Iron overload, Graft Versus Host Disease

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees or assurances have been made to me concerning the results of the chosen operation(s) or procedure(s).

6. The medically acceptable alternative(s) in treating such condition(s) has been explained to me and I understand it and the risks and benefits to be: No transfusion: inability to prevent or treat complications of low blood cells, other blood components & plasma volume, which may include damage to tissues due to poor oxygen delivery, hemodynamic instability, difficulty clotting and prolonged bleeding.

7. **IF TRANSFUSION IS A REASONABLE POSSIBILITY:** My doctor has discussed with me that there is a reasonable possibility that a transfusion of blood or blood products may be necessary. I have

Patient's or patient's legal representatives initials

Physician's initials

received a copy of the transfusion information form describing my transfusion options (unless I have a life-threatening emergency or medical contraindications). My doctor has discussed the risks, benefits and alternatives of the transfusion of blood and blood products with me. I have also learned about the option of pre-donating my own blood. By signing this consent form, I consent to the transfusion of blood or blood products, as my doctor may order, in connection with the operation(s) or procedure(s) discussed in this form.

- 8. I consent to the administration of sedation and/or anesthetics as may be considered necessary or advisable. I have been advised that there are certain risks associated with anesthetics that may include allergic reactions and/or drug intolerances, cardiac arrest and brain damage.
- 9. I recognize that, during the course of the operation or procedure, unforeseen conditions may necessitate other procedure(s), which are in addition to, or different from those set forth in paragraph 1. I understand that it may be difficult or impractical to obtain my consent for those procedure(s). I therefore authorize and request that the doctor, his/her assistant, or his/her designees perform such procedures as are in the exercise of professional judgment necessary and desirable, including, but not limited to, procedures involving surgery. The authority granted under this paragraph shall extend to treating all conditions that require urgent treatment and are not known to the doctor at the time the operation or procedure is commenced.
- 10. I authorize the pathologist, at his or her discretion, to retain, preserve, use, or dispose of any tissues, organs, bones, bodily fluid or medical devices that may be removed during the operation(s) or procedure(s). I understand that such specimens may be used for research, as permitted by federal and state law. I understand that I have no property ownership or interest in such specimens or data derived from those specimens and no right or entitlement in any research or research product using or derived from the specimens.
- 11. I understand that there may be health care industry representative or other visitors present, with the approval of UCDCMC, during my operation(s) or procedure(s) for purposes of medical observation or to provide technical support. I authorize those individuals to be present.
- 12. My doctor does not have any independent financial or research interest in the operation/procedure, other than usual or customary, unless checked here.
 - My doctor has informed me he/she does have independent financial or research interest in this operation/procedure.
- 13. I understand that if an implantable device is used, information regarding the device and my Social Security Number may be reported to the device manufacturer, if requested, and as required by Federal law.

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14. I understand that I have the right to refuse this operation(s) or procedure(s) at anytime. I further understand that the explanations I have received may not be exhaustive and all-inclusive and that other more remote risks may be involved. However, the information that I have received is sufficient for me to consent to the operation or procedure described above. I have had full opportunity to ask questions concerning my condition, the authorized operation(s) or procedure(s), the alternatives, and the risks and consequences associated with it. All the questions I have asked have been answered to my satisfaction.

15. **I have read and understand the above consent. I acknowledge the risks, benefits and alternatives associated with and wish to proceed with the operation(s) or procedure(s) described above.**

_____ DATE	_____ TIME	_____ PATIENT OR PATIENT'S LEGAL REPRESENTATIVE
		_____ RELATIONSHIP OF REPRESENTATIVE TO PATIENT (If applicable)

_____ DATE	_____ TIME	_____ PHYSICIAN / PROVIDER	_____ PI Number
		_____ TRANSLATOR (If applicable)	

Unforeseen circumstances require changing the individual practitioners involved in conducting the surgery or a change in the operation(s) or procedure(s) listed above. Please identify: _____

_____ DATE	_____ TIME	_____ PATIENT OR PATIENT'S LEGAL REPRESENTATIVE
		_____ PHYSICIAN/PROVIDER
		_____ PI Number

Patient's or patient's legal representatives initials

Physician's initials