Health Care
University of Missouri Health System

CONSENT TO OPERATIVE, SPECIAL PROCEDURES AND BLOOD TRANSFUSIONS

[redacted] (Patient's name) hereby authorizes Dr. H + assistants (physician(s)/practitioner(s)) and whomever may be designated as assistants to perform the following: (operation or procedure) Diagnostic Angiogram +/- embolization including Y90 Treatment

Moderate or deep sedation is planned for this procedure: ☒ Yes ☐ No General anesthesia is planned for this procedure: ☐ Yes ☒ No

USE FOR OPERATIVE/SPECIAL PROCEDURES

- I understand the possible risks of this procedure to include, but are not limited to: ① Damage to vasculature or surrounding structures ② Bleeding ③ Infection ④ Contrast related injury ⑤ Ischemia
- I understand the potential benefits of this procedure to include, but are not limited to: Diagnostic and/or therapeutic
- I was informed the possible alternatives include, but are not limited to: Deferral

- During my procedure I may be asleep (general anesthesia). If I have concerns or questions related to my anesthesia, I have the opportunity to discuss them in advance with my anesthesia provider. ☒ Yes ☐ No
- I authorize the administration of moderate sedation as deemed advisable by the physician(s)/practitioner(s) performing or assisting in the procedure. The risks, benefits, and alternatives of the moderate sedation as well as the types of moderate sedation have been explained to me and I fully understand my options. ☒ Yes ☐ No
- I acknowledge that no guarantee or assurance has been made to me of the results that may be obtained. ☒ Yes ☐ No
- I consent to have any tissue or parts removed during the procedure used for diagnostic purposes. ☒ Yes ☐ No
- In order to advance the understanding of medical education, treatment and other clinical activities, I consent to the admission of observers into the procedure room, and to the taking and publication of photographs or video clips, during the course of this procedure. ☒ Yes ☐ No
- I understand that my physician(s)/practitioner(s) will be immediately available for the entirety of my procedure and will be present in the OR for all key portions of my procedure. I understand that my physician(s)/practitioner(s) may participate in overlapping procedures during the time I am in the OR. ☒ Yes ☐ No

☐ NOT APPLICABLE **USE FOR BLOOD TRANSFUSIONS (NON-OPERATIVE & OPERATIVE)**

☒ **BLOOD TRANSFUSION:** I authorize the administration of blood/blood components as deemed necessary by the physician/practitioner for as often as may be needed. Potential complicating risks and alternatives have been explained. Including:

- Occasional complications: Fever, chills, allergic reactions (such as hives), transmission of hepatitis virus without symptoms, transmission of infectious diseases unknown at this time.
- Rare complications: Transmission of hepatitis with clinical symptoms and heart failure due to too much transfused fluid.
- Very rare complications: Hemolysis (destruction of transfused red blood cells), transmission of infectious diseases besides hepatitis (including AIDS), shock, chest pain, and death.

☐ **BLOOD REFUSAL:** I request that no blood or blood components or derivatives be administered during this hospitalization. I fully understand the possible consequences of refusal to permit blood transfusion. These consequences include, but are not limited to:

SIGNATURES REQUIRED

I HEREBY CONSENT TO THE PROCEDURE/TRANSFUSION OUTLINED ABOVE AND AUTHORIZE THE PHYSICIAN(S)/PRACTITIONER(S) LISTED TO PERFORM THIS PROCEDURE/TRANSFUSION. I CERTIFY AND ACKNOWLEDGE THAT I HAVE READ THIS FORM OR HAD IT READ TO ME, THAT I FULLY UNDERSTAND THE RISKS, BENEFITS, AND ALTERNATIVES AND THAT I HAD AMPLE TIME TO ASK QUESTIONS AND CONSIDER MY DECISION. UPON YOUR AUTHORIZATION AND CONSENT, THIS OPERATION OR PROCEDURE TOGETHER WITH ANY DIFFERENT OR FURTHER PROCEDURES WHICH IN THE OPINION OF THE DOCTOR(S) PERFORMING THE PROCEDURE MAY BE INDICATED DUE TO ANY EMERGENCY OR AN UNFORSEEN CONDITION OF SUFFICIENT SEVERITY SUCH THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED TO RESULT IN SERIOUS IMPAIRMENT OR HARM TO THE HEALTH OR LIFE OF THE PATIENT. X [redacted] Patient Initials.

X 1/3/18	[redacted]	[redacted]	
Date and Time	Signature of Patient	Date and Time	Signature of Provider
Date and Time	Signature of Parent/Guardian or Witness	Relationship to Patient	

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