6/8/2018 9:55 AM

The Jewish Hospital / Mercy Health 4777 East Galbraith Road Cincinnati, Ohio 45236

Acknowledgment of Informed Consent for Surgical or Medical Procedure and Sedation

I agree to allow doctor(s) **CORY BARRAT** and his/her associates or assistants, including residents and/or other qualified medical practitioner to perform the following medical treatment or procedure and to administer or direct the administration of sedation as necessary:

Procedure(s): **EXCISIONAL HEMORRHOIDECTOMY**

My doctor has explained the following regarding the proposed procedure:

- the explanation of the procedure
- the benefits of the procedure
- the potential problems that might occur during recuperation
- the risks and side effects of the procedure which could include but are not limited to severe blood loss, infection, stroke or death
- the benefits, risks and side effect of alternative procedures including the consequences of declining this procedure or any alternative procedures
- the likelihood of achieving satisfactory results.

I acknowledge no guarantee or assurance has been made to me regarding the results.

I understand that during the course of this treatment/procedure, unforeseen conditions can occur which require an additional or different procedure. I agree to allow my physician or assistants to perform such extension of the original procedure as they may find necessary.

I understand that sedation will often result in temporary impairment of memory and fine motor skills and that sedation can occasionally progress to a state of deep sedation or general anesthesia.

I understand the risks of anesthesia for surgery include, but are not limited to, sore throat, hoarseness, injury to face, mouth, or teeth; nausea; headache; injury to blood vessels or nerves; death, brain damage, or paralysis.

I understand that if I have a Limitation of Treatment order in effect during my hospitalization, the order may or may not be in effect during this procedure.

I give my doctor permission to give me blood or blood products. I understand that there are risks with receiving blood such as hepatitis, AIDS, fever, or allergic reaction. I acknowledge that the risks, benefits, and alternatives of this treatment have been explained to me and that no express or implied warranty has been given by the hospital, any blood bank, or any person or entity as to the blood or blood components transfused.

NA At the discretion of my doctor, I agree to allow observers, equipment/product representatives and allow photographing, and/or televising of the procedure, provided my name or identity is maintained confidentially.

I agree the hospital may dispose of or use for scientific or educational purposes any tissue, fluid, or body parts which may be removed.

[redacted] Date 6/19/18 Time 5:35 am/pm

(Circle One) Patient or Signature of Closest Relative or Legal Guardian

[redacted] Date 6/19/18 Time 0544 am/pm

Witness