MedStar Georgetown University Hospital

CONSENT FOR SURGERY, ANESTHETICS, AND OTHER MEDICAL SERVICES

1. I hereby authorize Dr.(s) Emily Winslow
[redacted] d whomever he/she may designate as his/her assistants to perform upon (patient name) the following surgical, medical or diagnostic procedure(s): (physician(s) ned) Left Hepatectomy wedge Resection Diagnostic Laparoscopy

2. I acknowledge that my physician(s) discussed with me the proposed care, treatment and services. I have been advised of the potential benefits, risks, side effects and likelihood of achieving goals. I also have been advised of any potential problems that might occur during recuperation. I have been advised of reasonable alternatives to proposed care, treatment, services and risks, benefits and side effects related to the alternative treatment and the risk related to not receiving the proposed care, treatment and services. I understand that in the course of the procedure the physician(s) may determine that procedures in addition or different from this procedure may be necessary to my well being and that it would not be practical to obtain further consent at the time. I therefore authorize the doctor(s) to perform such procedures without further consultation with me.
3. I have been provided information that in certain circumstances information about my care, treatment and services may be disclosed as required by law or regulation. Certain circumstances may include mandatory reporting requirements to the centers for Disease Control, health department or Food and Drug Administration.
4. My physician, the responsible physician(s), will be present for all critical parts of the procedure even in the event of overlapping procedures (see reverse, if applicable). Other medical professionals may perform some non-critical aspects of the procedure as my responsible physician deems appropriate. I understand that MedStar is a teaching organization. This means that resident doctors, doctors in medical fellowship (fellows) and students in medical, nursing and related health care professions receive training here, and may take part in my procedure, under the oversight and supervision of the responsible physician.
5. I also consent to the administration of anesthetics by or under the direction of the physician that has been trained to perform the required local anesthetic or moderate or deep sedation. The physician has explained the risks, benefits, side effects, and alternatives of the intended anesthesia.
6. For purposes of research, medical education or documentation of my medical condition in the medical record, I consent to the taking of photographs or films during the course of the procedure(s). I understand that my identity will not be revealed if the photographs or films are used for medical education or research, and in all instances patient confidentiality will be preserved. I understand that copies of the prints will be given to me if I ask for them.
7. [redacted] re that the practi[redacted] is not an exact science, that there is no certainty that the desired benefits will [redacted] r assurances have been made to me concerning the outcome.

9-10-19 0835 Self
Date Time Relation to Patient

9-10-2019 0835h
Date Time

~~AL TELEPHONE CONSENT~~
ntative is not available to sign the above consent)

Relation to Patient

= winslow 9/10/19
Date Time

Signature of Witness to Verbal Consent Date Time

☐ **NON-OR SAFE SURGERY CHECKLIST:**

Team Pause Date: _____ Time: _____ Signature & Title _____

☐ Patient receiving anticoagulation: ☐ Yes ☐ No ☐ Coagulation abnormalities addressed: ☐ Yes ☐ No
☐ Correct Patient Identity ☐ Agreement on Procedure to be Done.
☐ Correct Site & Side Marked: ☐ Left ☐ Right ☐ N/A
☐ Correct Patient Position ☐ Availability of All Anticipated Equipment, Meds and/or Supplies
☐ Patient History Checked

Additional Information for Overlapping Procedures

What is an Overlapping Procedure?
An overlapping procedure is the practice of the surgical team preparing one patient for a procedure in one room while at the same time other team members finish another patient's procedure in a separate room. National studies have found no difference in complications from procedures where overlapping occurs. There are very strict rules that apply; during an overlapping procedure. The responsible physician must complete the key portions of any overlapping procedure.

What to Expect for Your Surgery or Procedure
Your care team is led by your "Responsible Physician". This is the surgeon responsible for your procedure. Your Responsible physician:

- Will be in the procedure room for the critical portions of your procedure.
- May not be in the room with your care team for noncritical portions of your procedure.
- Will be immediately available to return to the room and assist your care team if needed.
- Will ensure the team members performing the noncritical portions are qualified and capable of performing their part.
- May begin to be involved in the care of another patient before and after the critical portions of your procedure are completed. In this situation, another physician is identified in advance to assist the care team-in the rare circumstance in which help is needed.
- Will not perform critical portions of a procedure on another patient in another room at the same time as critical portions of your procedure are being completed, except in the case of an emergent or life threatening situation with another patient.

In addition to the Responsible Physician, your care team may include the following members: anesthesiologist, certified registered nurse anesthetist, operating room or procedure room nurse, surgical technologist, residents, fellows or medical/ nursing and related health care professional students, and a physician assistant.

Surrogate Decision Maker / Personal Representative Priority List for Adult Patients

Following certification of physical or mental incapacity, a surrogate decision maker / personal representative is a person authorized to make healthcare decisions on behalf of another individual by a durable power of attorney for health care (Advance Directive). In the absence of a document naming a surrogate decision maker / personal representative, the following individuals, in the order or priority set forth below, are authorized in the District of Columbia, to grant, refuse or withdraw consent of behalf of the patient with respect to the provision of any health care service, treatment, or procedure:

1. A court appointed guardian or conservator of the patient.
2. The spouse or domestic partner (any adult living with, but n relationship, including any adult registered as a domestic pa
3. An adult child of the patient.
4. A parent of the patient.
5. An adult sibling of the patient.
6. A religious superior of the patient, if the patient is a membe
7. A close friend of the patient (any adult who has exhibited significant care and concern for the patient, has maintained regular contact with the patient, and is familiar with the patient's activities,health, religious and moral beliefs). The friend may **NOT** be a healthcare provider, an owner, operator, administrator, an employee, of or a person with decision-making authority for, a health-care provider that is providing services to the patient at the time of healthcare decision.
8. The nearest living relative of the patient.

If no individual in the prior class is reasonably available, mentally, capable and willing to act, the responsibility for decision making shall rest with the next reasonably available, mentally capable, and willing person on the priority list.

PLEASE NOTE: The order of priority established above in 3-8 is presumed. However, it can be rebutted if a person of lower priority is found to have better knowledge of the wishes of the patient, or if the wishes of the patient are unknown and cannot be ascertained, is better able to demonstrate a good-faith belief as to the interests of the patient.

Verbal consent by the Surrogate Decision Maker: When the surrogate decision maker is not physically present, the Procedure Practitioner will contact the surrogate decision maker and review the material risks, benefits and alternatives and likely consequences if treated is refused. With the permission of the surrogate decision maker, an individual, will monitor the telephone conversation. The pertinent aspects of the conversation will be recorded in the patient's chart.

If the patient is a minor, or you have other questions, please refer to the details in GUH Policy 117. If there is a question or dispute regarding the priority, contact MedStar Legal Services through the page operator.

Certification of Mental Incapacity: Two physicians, one of whom must be a psychiatrist, must certify in writing in the patient's chart that the patient is incapable of understanding the healthcare choice and making a decision concerning treatment.

GEORGETOWN UNIVERSITY HOSPITAL
CONSENT FOR TREATMENT, RELEASES, ACKNOWLEDGEMENT AND FINANCIAL AGREEMENT

BY MY SIGNATURE ON THE FRONT SIDE OF THIS FORM, I AGREE THAT I:

1. GENERAL CONSENT FOR TREATMENT. VOLUNTARILY CONSENT TO AND AUTHORIZE SUCH CARE AND TREATMENTS, INCLUDING BUT NOT LIMITED TO PHYSICAL OR MENTAL EXAMINATION, DIAGNOSTIC TESTS, MEDICAL PROCEDURES AND MEDICATION ("TREATMENTS") BY EMPLOYEES AND AUTHORIZED AGENTS OF GEORGETOWN UNIVERSITY HOSPITAL ("HOSPITAL") AS MAY BE CONSIDERED NECESSARY OR ADVISABLE IN THEIR PROFESSIONAL JUDGEMENT, AND MAY INCLUDE THE DRAWING AND TESTING FOR HIV (THE VIRUS THAT CAUSES AIDS) AND OTHER BLOOD BORNE DISEASES. I FURTHER ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE REGARDING THE EFFECT OF SUCH TREATMENTS ON ANY MEDICAL CONDITION
2. RIGHT TO REFUSE TREATMENTS. UNDERSTAND THAT I HAVE THE RIGHT TO MAKE INFORMED DECISIONS REGARDING ALL CARE AND TREATMENTS, AND THAT I SHOULD ASK MY HEALTH CARE PROFESSIONALS TO FURTHER CLARIFY OR EXPLAIN ANYTHING I DO NOT UNDERSTAND. THIS RIGHT INCLUDES THE RIGHT TO REFUSE ANY TREATMENTS THAT I DO NOT WANT.
3. ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY. AUTHORIZE AND ASSIGN ALL CLAIMS FOR AND PAYMENTS OF ANY INSURANCE BENEFITS, WORKERS'ASSIGN COMPENSATION BENEFITS, GOVERNMENT AGENCY AND DISABILITY BENEFITS, DIRECTLY TO THE HOSPITAL FOR SERVICES RENDERED. I FURTHER ASSIGN THE PROCEEDS OF ANY SETTLEMENTS, JUDGMENTS OR VERDICTS FROM THIRD PARTY LIABILITY CLAIMS FOR INJURIES TREATED BY THE HOSPITAL TO THE HOSPITAL IN AN AMOUNT EQUAL TO THE OUTSTANDING BALANCE OF ALL CHARGES DUE AND OWING. I AGREE THAT ANY EXCESS PAYMENTS MAY BE APPLIED BY HOSPITAL PARTY, OR GUARANTOR OF PAYMENT FOR PATIENT, I AGREE TO BE RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THE PATIENT'S INSURANCE COVERAGE OR OTHER CLAIMS. I FURTHER AGREE THAT IN THE EVENT PAYMENT IS NOT MADE IN FULL FOR ALL HOSPITAL CHARGES, THAT TO THE EXTENT PERMITTED BY APPLICABLE LAW, I SHALL PAY ALL HOSPITAL COSTS OF COLLECTION INCLUDING REASONABLE ATTORNEY'S FEES AND/OR COLLECTION AGENCY FEES.
4. PROPERTY RELEASE. RELEASE THE HOSPITAL FROM ANY RESPONSIBILITY FOR VALUABLES, MONEY, PERSONAL OR OTHER POSSESSIONS WHICH ARE NOT PROPERLY DEPOSITED BY ME WITH THE HOSPITAL DEPOSITORY AND THAT IN ANY EVENT THE HOSPITAL'S MAXIMUM LIABILITY SHALL BE $500.00.
5. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. ACKNOWLEDGE THAT I HAVE RECEIVED OR DECLINE THE MEDSTAR HEALTH NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGE THAT THIS NOTICE IS AVAILABLE FOR ME TO KEEP.

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FOR GEORGETOWN UNIVERSITY HOSPITAL USE ONLY

PATIENT SIGNATURE/ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES NOT OBTAINED BECAUSE:

__ EMERGENCY PATIENT
__ PATIENT/PATIENT REPRESENTATIVE DECLINED TO ACKNOWLEDGE RECEIPT
__ PATIENT/PATIENT REPRESENTATIVE UNABLE/UNWILLING TO ACKNOWLEDGE RECEIPT

_____
GUH Representative

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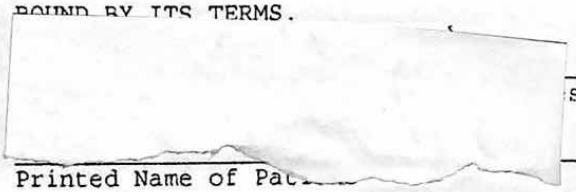
BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS OF THIS FORM AND THAT I AM AUTHORIZED AS THE PATIENT OR THE PATIENT'S REPRESENTATIVE TO SIGN THIS DOCUMENT AND BE BOUND BY ITS TERMS.



_____ sentative Date 2/24/2020

_____ _____
Printed Name of Pat... Relationship to Patient

MedStar Georgetown University Hospital

CONSENT FOR SURGERY, ANESTHETICS, AND OTHER MEDICAL SERVICES

PATIENT LABEL

1. I hereby authorize Dr.(s) George Lynskey an associates
(the primary surgeon(s)/practitioner(s)) and whomever he/she may designate as his/her assistants to perform upon myself (patient name) the following surgical, medical or diagnostic procedure(s): (physician(s) to state the specific procedure to be performed) US image guided liver mass biopsy and normal liver biopsy

2. I acknowledge that my physician(s) discussed with me the proposed care, treatment and services. I have been advised of the potential benefits, risks, side effects and likelihood of achieving goals. I also have been advised of any potential problems that might occur during recuperation. I have been advised of reasonable alternatives to proposed care, treatment, services and risks, benefits and side effects related to the alternative treatment and the risk related to not receiving the proposed care, treatment and services. I understand that in the course of the procedure the physician(s) may determine that procedures in addition or different from this procedure may be necessary to my well being and that it would not be practical to obtain further consent at the time. I therefore authorize the doctor(s) to perform such procedures without further consultation with me.
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7. I a[illegible] an exact science, that there is no certainty that the desired benefits will b[illegible] rances have been made to me concerning the outcome.

X Pati[illegible] 6/25/19 1607 myself
Date Time Relation to Patient

Witn[illegible] 6/25/19 1607
Date Time

ELEPHONE CONSENT
is not available to sign the above consent)

Authorized Representative Name — Relation to Patient

Signature of Physician/ Practitioner Obtaining Consent — Date — Time

Signature of Witness to Verbal Consent — Date — Time

☐ **NON-OR SAFE SURGERY CHECKLIST:**

Team Pause Date: _____ Time: _____ Signature & Title _____

☐ Patient receiving anticoagulation: ☐ Yes ☐ No ☐ Coagulation abnormalities addressed: ☐ Yes ☐ No
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1. A court appointed guardian or conservator of the patient.
2. The spouse or domestic partner (any adult living with, but not married to, the patient in a committed intimate relationship, including any adult registered as a domestic partner).
3. An adult child of the patient.
4. A parent of the patient.
5. An adult sibling of the patient.
6. A religious superior of the patient, if the patient is a member of a religious order or a diocesan priest.
7. A close friend of the patient (any adult who has exhibited significant care and concern for the patient, has maintained regular contact with the patient, and is familiar with the patient's activities,health, religious and moral beliefs). The friend may **NOT** be a healthcare provider, an owner, operator, administrator, an employee, of or a person with decision-making authority for, a health-care provider that is providing services to the patient at the time of healthcare decision.
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