PATIENT [redacted] Age [redacted]

1. As discussed with me by Dr.(s) Shen Yue that this Physician and his/her resident physicians,/physician associates(s)/assistant(s) (list if known): _____) are authorized by me to perform the surgical or medical procedure known as (name or describe): Right Revision Total Knee Arthroplasty, Debridement, Graham Exchange of Polyethylene Insert / Tibial Insert

2. As explained to me, I understand that this medical or surgical procedure is for the purpose of (describe fully): Staged TKA Revise Stiffness

and although no specific result has been guaranteed, it is expected to accomplish the following (list benefits and include likelihood of achieving) : Reduce Pain

3. **(Please select A, B or C)**

A. ☒ I consent to the use of anesthesia under the direction and supervision of the UTMC Department of Anesthesiology (I understand that I can request to see a list of the Anesthesiology faculty, and such list will be provided upon my request). All of my questions have been answered about the use of this anesthesia. I understand that the attending anesthesiologist may be assisted by resident physicians, certified registered nurse anesthetists or anesthesiology assistants. I consent to the use of the anesthetics that the anesthesiologist has advised, with the exception of (none or a particular one):_____

B. ☐ I consent to the use of sedation (to relax me) and/or analgesia (to prevent and relieve my pain), to be administered by or under the direction and supervision of Dr.(s) _____ All of my questions have been answered about the use of sedation and/or analgesia. I consent to the use of such drugs as determined by the anesthesiologist, with the exception of (none or a particular one):_____

C. ☐ *I DO NOT authorize sedation and have been advised of the potential risks of no sedation.*

4. **(Please select A or B):**

A. ☒ I authorize the use of blood and blood products determined to be necessary by my physician(s). I understand that this involves risk of hepatitis, Human Immunodeficiency Virus (HIV) or other adverse reactions. There can be no assurance against these risks. I have been informed about alternative means of therapy.

B. ☐ *I refuse to authorize the use of blood or blood products. My physician has explained alternative means of therapy and the expected or potential consequences of this refusal.*

THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

Informed Consent to Medical or Surgical Procedure

[redacted]

Patient Label

5. As explained to me, I understand that any surgery or medical procedure(s), involve elements of risk. As also explained to me, I understand that there may be risks which are unexpected or not reasonably known. I further understand that in my case, the reasonably known material risks include those listed here:
Bleeding, infection, Neurovascular/Tendon injury, Recurrent Stiffness, Infection, Recurrence, IV antibiotics, Need for staged knee Replacement

6. I recognize that, during the course of the surgery or medical procedure unforeseen conditions may necessitate additional or different procedures from those listed above. In emergency situations, my physician is permitted to proceed with necessary additional or different procedures that are in my best interest.
DVT, PE, MI, Mortality < 1%, Recurrent Stiffness, Need for Revision total knee arthroplasty in future.

7. I acknowledge that the physician(s) has(have) explained to me the nature and purpose of the procedure(s) and what the procedure(s) is (are) expected to accomplish together with the reasonably known risks. I understand that I have a right to refuse the recommended procedure. I have been informed of alternative methods of treatment. I have also been informed of the likely results if I remain untreated. I have had an opportunity to ask questions and all of my questions have been answered in a satisfactory manner.

I hereby state that I have read and understand t[redacted]

Signature of Patient (If necessary Legal Represen[redacted]nship self

Witness________________________ Date: 7/10/2020 Time: 930 (☐A.M ☐P.M.)

(Witness is the person who observes the signature of the patient [or the patient's legal representative]. The witness may be the Physician/Resident, assistant, or any hospital staff member. The witness may be the same person below, assisting in completion of the form.) The witness signature line must always be completed (even if the witness and the person assisting in the completion of the form are the same).

Printed Name & Position of Person assisting in completion of Form: ________________________

(This person may be the Physician/Resident providing the informed consent discussion or may be an assistant to the Physician/Resident familiar with the informed consent. If an assistant completes the form, the Physician/Resident must document the informed consent process in the medical record.)

Signature of Person assisting in completion of Form: ________________________

Time: 930AM Date: 7/10/2020