☐ attempts to resuscitate me only if, in the clinical judgment of my physicians, the adverse clinical events are believed to be temporary and reversible.

☐ full resuscitation measures except:

8. **Procedures Involving Central Line Placement**

The importance of preventing infection related to placement of a central line and the following instructions have been discussed with me:

☐ I have been instructed to keep the insertion site clean and the dressing Intact.

☐ I have been instructed to notify my healthcare provider in the event of any pain, redness, or drainage at the insertion site.

I certify and acknowledge that I have read this form or had it read to me, and have had ample time to ask questions and consider my decision. I understand the risks, alternatives and expected results of the planned anesthetic. I accept the anesthetic risks as described above.

Additional Risks/Benefits/Alternatives:

Invasive monitoring

Signature captured at 4/1/2021 06:17 AM

Lameko Young, Self

☐ **TELEPHONE OR VERBAL CONSENT ATTESTATION**

I attest verbal authorization for the anesthesia service in paragraph 3 above was obtained from the patient/personal representative named above who has stated that he/she has authority to consent on behalf of the patient following an explanation of the information in paragraphs 1 - 8 above.

Witness

Name of Interpreter (if used):

ured at 4/1/2021 06:17 AM

M

satisfaction. I understand that while use of the above anesthesia is planned, another form of anesthesia may be used if indicated.

4. I understand that I may experience some minor problems that may include but are not limited to temporary impairment of judgment, coordination, or attention span, nausea or vomiting, headache, sore throat, muscle aches, bruises or tenderness at the site of intravenous infusions; injury to teeth, gums or lips; injury to eyes, or injury related to positioning during surgery.

5. I understand that the frequency of serious complications related to anesthesia depends upon a patient's general health prior to anesthesia and the seriousness of the contemplated procedure. It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications can occur with anesthesia and include but are not limited to infection, bleeding, drug reactions, blood clots, loss of sensation; loss of limb function, paralysis; stroke, brain damage, heart attack or death.

6. I have been informed that medications that I am taking may cause complications with anesthesia or surgery. I understand that it is necessary to inform my doctors about the nature of any medications or drugs I am taking, including aspirin, narcotics, PCP, marijuana, and cocaine.

7. **Do-Not-Resuscitate Order and / or Advance Directive**

☑ I do not have a "Do-Not-Resuscitate" order or "Advanced Directive" in effect.

☐ I have a "Do Not Resuscitate" order or "Advanced Directive", however, during my procedure, my anesthesia and during my post procedure care

- ☐ full resuscitation measures be employed regardless of the cause.
- ☐ attempts to resuscitate me only if, in the clinical judgment of my physicians, the adverse clinical events are believed to be temporary and reversible.
- ☐ full resuscitation measures except:

8. **Procedures Involving Central Line Placement**

The importance of preventing infection related to placement of a central line and the following instructions have been discussed with me:

- ☐ I have been instructed to keep the insertion site clean and the dressing Intact.
- ☐ I have been instructed to notify my healthcare provider in the event of any pain, redness, or drainage at the insertion site.

may be selected by him/her at the University of Illinois Hospital & Health Sciences System Department of Anesthesiology

2. I understand that my anesthesiologist may be assisted by resident physicians or doctors in training at University of Illinois Hospital & Health Science Systems

3. I consent to receive the anesthesia service: **general**

General Anesthesia	**Expected Result** Total unconscious state, possible placement of a tube into the windpipe **Technique** Drug injected into the bloodstream, breathed into the lungs, or by other routes **Risks** Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia
Spinal or Epidural Analgesia/Anesthesia	**Expected Result** Temporary decreased or loss of feeling and/or movement to lower part of the body **Technique** Drug injected through a needle/catheter placed either directly into the spinal canal or immediately outside the spinal canal **Risks** Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels
Major / Minor Nerve Block **Intravenous Regional Anesthesia**	**Expected Result** Temporary loss of feeling and/or movement of a specific limb or area **Technique** Drug injected near nerves providing loss of sensation to the area of the operation **Risks** Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels
Monitored Regional Care (MAC)	**Expected Result** Reduced anxiety and pain, partial or total amnesia **Technique** Drug provided through routes producing a semi-conscious state **Risks** An unconscious state, depressed breathing, injury to blood vessels

The anesthetic as described above, its risks and alternatives have been explained to my satisfaction. I understand that while use of the above anesthesia is planned, another form of anesthesia may be used if indicated.

ATTESTATION OF INFORMED CONSENT

I attest that prior to the time of the procedure, I provided to the patient and/or his/her personal representative the information contained in paragraph 1 thru 6 above verbally and/or by means of an information sheet or other audio/visual means of communication.

PHYSICIAN OR FELLOW SIGNATURE

/2021 10:32 AM

PATIENT ATTESTATION OF INFORMED CONSENT

2021 10:38 AM

TELEPHONE CONSENT ATTESTATION

I attest verbal authorization for the procedure(s) / treatment in paragraph 1 above was obtained from the patient/personal representative named above who has stated that he/she has authority to consent on behalf of the patient following an explanation of the information in paragraphs 1 thru 6 above.

Witness

INTERPRETER

Interpreter

Print Name of Interpreter / Qualified Bilingual Staff / or the Identification Number of the Telephonic Interpreter

UI Health | UIC

SHORT FORM INFORMED CONSENT FOR PERFORMANCE OF OPERATION OR OTHER PROCEDURE AND / OR ADMINISTRATION OF ANESTHESIA NOT FOR USE IN MAIN OPERATING ROOM

1. I voluntarily consent to the following procedure: Endoscopic ultrasound and endoscopic retrograde cholangiopancreatography with possible fine needle aspiration/biopsy, cautery, clipping, injection, sphincterotomy, stent placement, endoscopic ultrasound guided rendezvous/biliary drainage, cholangioscopy

That I have reviewed with the following provider: BOULAY, BRIAN

To be performed by my primary credentialed practitioner ("CP") AND a designated team under his/her supervision, which may include Fellow(s), Resident(s), medical student(s), Physician Assistant(s), nurse(s), technologist(s), and other qualified personnel ("Team").

2. I consent to the administration of anesthesia, including procedural sedation as may be considered necessary or desirable in the judgment of my CP.

3. I consent to other treatments or procedures which are necessarily incidental to the surgery/procedure and agree that the same may be administered by members of the Team or other qualified personnel working under the supervision of the CP.

4. I consent to any of my removed tissues, organs, body parts, or prosthetic(s) (e.g., artificial joint) being disposed or otherwise used by the University of Illinois Hospital as outlined in the General Consent to Treatment Authorization Form.

5. I consent to videography, photographing, televising or other imagery of the operative procedure for the sole purpose of medical education. I understand that my identity will not be revealed by pictures or descriptive texts.

6. I understand and have discussed my condition and/or diagnosis, the nature of the surgery/procedure, and that results of this surgery/procedure cannot be promised, warrantied, or guaranteed. I understand and have discussed the material risks and prospects of success of this surgery/procedure and the probable consequences of not having it done. I also understand and have discussed alternative treatment options and their material risks and prospects of success. **I had the opportunity to ask further questions on these matters and all of my questions have been answered to my satisfaction.**

ATTESTATION OF INFORMED CONSENT

I attest that prior to the time of the procedure, I provided to the patient and/or his/her personal representative the information contained in paragraph 1 thru 6 above verbally and/or by means of an information sheet or other audio/visual means of communication.

PHYSICIAN OR FELLOW SIGNATURE

)NSENT

TELEPHONE CONSENT ATTESTATION

I attest verbal authorization for the procedure(s) / treatment in paragraph 1 above was obtained from the patient/personal representative named above who has stated that he/she has authority to consent on behalf of the patient following an explanation of the information in paragraphs 1 thru 6 above.

Witness

INTERPRETER

Interpreter

Print Name of Interpreter / Qualified Bilingual Staff / or the Identification Number of the Telephonic Interpreter

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4. I consent to any of my removed tissues, organs, body parts, or prosthetic(s) (e.g., artificial joint) being disposed or otherwise used by the University of Illinois Hospital as outlined in the General Consent to Treatment Authorization Form.
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