THE UNIVERSITY OF KANSAS HEALTH SYSTEM
4000 Cambridge Street
Kansas City, Kansas 66160

Do not write in this box

DT5139
Consent for Surgery – Procedure

Name: [redacted]
DOB:
MRN:

DOCUMENTATION OF INFORMED CONSENT FOR AMBULATORY PROCEDURES

1. **Physician(s)/Practitioner** [redacted] will perform the following procedure(s):
   [redacted]
2. **Procedure Site (mark one box, or for multiple procedures, indicate sites above):**
   ☐ Right-side ☐ Left-side ☐ Bilateral ☐ Level: [redacted]
3. **I agree to administration of local anesthesia under the direction of my provider, as he or she believes advisable for the operation or procedure I am having.**
4. **I understand The University of Kansas Health System is a teaching organization** and that, under the supervision of my provider, resident providers and other learners may be observing or assisting in my treatment or procedure and may assist in opening and closing, dissecting tissue, and/or removing tissue. I also understand that nurses and other health care workers will be caring for me during my treatment or procedure.
5. **My provider and I have discussed** my condition and his/her recommended treatment. No guarantees or promises have been made to me that the recommended treatment or operation will improve my condition.
6. **I understand** that all treatment or procedure involve general risks such as bleeding, infection, allergic reaction, problems with my heart or blood pressure and even death. My provider has explained these general risks and specific risks and possible side effects of this treatment or procedure, including:
   [redacted]
   (Specific risks or concerns discussed with the patient)
7. **I agree that anything removed from me during the treatment or operation may be used for** teaching, diagnosis, research, or disposed of by the hospital as usual.
8. **I have had the chance to ask questions and my questions have been answered to my satisfaction.** The procedures, treatments, other alternative procedures, methods of treatment, and risks have been explained to me in substantial detail. I am satisfied with my practitioner or physician's explanations. I give my permission and consent to the treatment(s) or procedure(s) specified above.

[redacted]	[redacted]		
(Patient's Signature)	(Printed Name)	(Date)	(Time)

If an interpreter was involved with the informed consent process, document the interpreter's name or ID number: _____

** If the patient is unable to consent (i.e. patient is minor, has legal guardian, or incapacitated), complete the back side of this form, including section A, B, or C.*

If a patient has decisional capacity, but inability to write his/her name, the patient can make a mark above. Reason for mark noted: _____

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