MAYO CLINIC

Procedural Consent

Form content retained in medical record.
Route to HIMS Scanning.

TO BE SCANNED

(complete fields or place patient label here)

[redacted] (First, Middle, Last)
MRN: [redacted] CSN: [redacted]
Pichla, Robert D. "Bob"
DOB: [redacted] Male Encntr Dt: 3/31/2022
[redacted]

I consent to the following procedure(s): please print
C6-7 ACDF, C6-7 laminectomy
C4-T2 posterior instrumented fusion

Procedure(s) Will Be Performed By (name of performing or supervising physician or licensed independent practitioner) [redacted]	Provider Pager

Risks, Benefits, Alternatives: My provider has explained to me the risks, benefits, and nature and consequences of the procedure, along with risk of complications, including, but not limited to failure, serious injury, and even death; the likelihood that I will achieve my goals; and any potential problems that might occur during recuperation. My provider also has explained the alternative viable modes of treatment, their benefits, risks, and effectiveness, as well as the risks and benefits of not undergoing treatment. The likely results of no treatment have been explained to me.

Anesthesia: If an anesthetic is administered, as discussed with my provider, it will be administered through general or regional anesthesia, such as spinal or epidural, or local anesthesia with sedation. I understand that all types of anesthesia involve risk due to unexpected reactions or complications. Potential complications include damage to teeth, mouth or throat, allergic reactions, pneumonia, inflammation of the veins, nerve injury, or paralysis, damage to the heart, liver, kidney or brain, infection, or the possibility of death.

Additional Procedures: I understand that additional procedure(s) may be necessary or desirable during the procedure(s) to treat or evaluate me. It is or may be foreseeable that unanticipated conditions may be revealed that require an extension of the original procedure, so I consent to such additional procedure(s) as are necessary and desirable in my provider's professional judgment.

Health Care Team: I understand that other providers, including physicians-in-training, physician assistants, surgical technicians or others may be involved. They may be identified by name in my medical record. For some surgeries, a provider other than the primary surgeon may perform significant tasks including opening and closing the wound, harvesting grafts, removing tissue, and implanting devices or altering tissues.

Overlapping Operations/Procedures in the Operating Room: I understand that my primary surgeon may be participating in another operative procedure during non-critical portions of my procedure. A qualified surgeon will be available.

Photography and Video: I consent to being photographed or videotaped for purposes of treatment and internal health care operations, such as improvement of quality of care and education of students and professionals. I also consent to the photography or videotaping of the procedure showing portions of my body for medical, scientific or educational purposes, provided that my identity is not revealed.

Transfusion of Red Blood Cells (RBCs), Granulocytes, Platelets, Frozen Plasma (FP), or Cryoprecipitate: As applicable, I have discussed with my provider the possibility of needing a blood transfusion or having autologous blood transfused using cell salvage during my treatment, and the risks and benefits of receiving blood or blood products, and viable medical alternatives. I understand the most common risks include but are not limited to: transfusion reactions such as fever, chills, allergic reaction, hives or shortness of breath, or discomfort at the site of administration. I also understand there is a risk of transfusion transmitted disease such as Hepatitis B, Hepatitis C, or HIV. I have had the opportunity to ask questions.

I consent to receiving all blood or blood products:

☐ Yes ☐ No ☐ Not applicable If "No" is selected, complete Consent and/or Refusal for Blood Products (MC3999-23).

Implants/Explants: If I have an implant/device placed, I authorize personnel to: (1) complete the registry card(s) associated with my implant/device that contains my personal health information; and (2) provide the card to the appropriate registry or data collection agency. I understand that any body tissue and/or medical devices removed during the procedure will be managed according to Mayo Clinic policy.

Exposure: If a Mayo Clinic employee is exposed to my blood or body fluids, I consent to have my blood drawn and tested and to the disclosure of my results to Mayo Clinic Occupational Health and the exposed employee for the purposes of treatment to the employee.

My questions have been answered. By signing below I agree to the procedure(s).

Patient/Representative Signature [redacted]	Date (mm-dd-yyyy) 03/31/2022	Time (hh:mm) ☐ am ☐ pm
Patient/Representative Printed Name (First, Middle, Last) [redacted]		
If Representative, Relationship to Patient W/F		

ENTERPRISE: Applies to Mayo Clinic locations in Arizona, Florida, Rochester and Mayo Clinic Health System.