Mayo Clinic Number [redacted]

Patient Name [redacted]

MAYO CLINIC

TO BE **SCANNED**

Patient Informed Consent

Mayo Clinic in Rochester, Minn.

Instructions: Complete form and print. This form collections information that is part of the medical record. Route to Scanning.

Department

General Surgery

☒ Rush for Next Day Surgery

I consent to the following procedure(s)

Laparoscopic abdominal exploration - Removal of Retorperitoneal ganglioneuroma); Possible Abdominal exploration - open Removal of Retroperitoneal ganglioneuroma

Procedure(s) Performed By (Performing/Supervising Physician or Licensed Independent Practitioner Name)

BINGENER-CASEY, JULIANE

Pager Number

89007

Risks, Benefits, Alternatives: My provider and health care team have explained the nature and purpose of the procedure(s). My provider and health care team have explained possible alternative treatments, including non-treatment. The substantial risks and benefits of the procedure(s) have been explained to me. I understand the risk of complications, including serious injury and even death. I understand that medicine may be used to sedate me or manage my pain. I understand that there is no guarantee as to the results. The explanation I have received does not include all possible risks.
Additional Procedures: I understand that additional procedure(s) may be necessary during the course of the procedure(s) to best treat or evaluate me. I consent to such additional procedure(s).
Health Care Team: I understand that other members of the health care team, including physicians in training, physician assistants, surgical technicians or others may be involved. These providers 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, taking grafts, cutting out tissue, and implanting devices.
Photography: I understand photographs and/or videotapes may be created during the procedure and used for purposes of my treatment or for internal purposes such as educational activities and quality improvement.
Blood Products: I understand that during the procedure(s) I may need blood products, either from a donor or myself. I understand the risks, benefits and alternatives and consent to their administration.
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 ensuring that the exposed employee receives appropriate treatment for the exposure.

My questions have been answered. I agree to the procedure(s). I have crossed out and put my initials beside any sentence I do not agree with. Any additional instructions are:

Signatures

Patient or Representative Printed Name [redacted]

Patient or Representative Signature

Date (Month DD, YYYY)

June 19, 2017

If Representative, Relationship to Patient

Witness to Signature

Time (24-hour clock)

5:40 pm

Contact the Help Desk (77)4-5500 for technical assistance.
Contact James Rogers, Systems and Procedures, (77)5-0188 for process-related assistance.