



# UC Irvine Health

## CONSENT FOR OPERATION/PROCEDURES OR RENDERING OF OTHER MEDICAL SERVICES

### SECTION I: SURGEON OR OTHER PHYSICIAN

Kenneth Chan, MD

1. I hereby authorize and direct \_\_\_\_\_ M.D. to perform the following operations or medical procedures upon the patient named above:

\_\_\_\_\_  
Name or description of operation(s) or procedure(s)

*Endoscopic ultrasound with possible fine needle aspiration or injection under general anesthesia.*

2. I hereby authorize and direct the above named surgeon to provide or arrange for the provisions of such additional services as he/she or they may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia and the performance of services involving pathology and radiology, and I hereby consent thereto.
3. The University of California, Irvine Healthcare is a research institution. I understand that any data or specimen(s) obtained during any examination, treatment, or procedure, including any laboratory or surgical procedure, of the patient may be used in research which may or may not be related to the patient's treatment or condition. Specimen means and includes, without limitation, any organ, tissue, bone or other bodily fluids of any kind. I further understand that the patient has no property or ownership interest in such specimen(s) or data and no right or entitlement in any research or research product using or derived from the specimen(s). I further authorize the pathologist to use his/her discretion in the disposition or use of any member, organ, or other tissue removed from my person during the operation(s) or procedure(s) identified above.
4. My physician does not have any independent financial or research interest in the procedure/treatment, other than usual or customary, unless checked below.  
 My physician has informed me he/she does have independent financial or research interest in this procedure/treatment.
5. I understand that there may be a healthcare industry manufacturer's representative present during the procedure/treatment and I consent to this, at the discretion and approval of my physician and hospital, unless checked below.  
 I do not consent to the presence of any healthcare industry manufacturer's representative.
6. The University of California is a teaching institution, I understand that Fellows and Residents, acting under the supervision of the primary surgeon/practitioner, may be performing important procedural tasks related to this surgery or procedure in accordance with hospital policy and based upon their skill set. These tasks may include but are not limited to: opening/closing, harvesting grafts, dissecting tissue, removing tissue, **transplanting tissue**, implanting devices and placing monitoring or invasive lines.  
 I also understand that qualified medical practitioners, who are not physicians (e.g. Physician's Assistants), may also be performing important procedural tasks that are within their scope of practice as determined by California state law and regulation and for which they have been granted privileges by the University of California, Irvine Healthcare.

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.  
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**SECTION II: PHYSICIAN STATEMENT OF INFORMED RISKS AND COMPLICATIONS**

The nature and purpose of the operation or medical procedure has been explained by a member of the procedure team. The risks, complications, and expected benefits of such operation and/or medical procedure and/or sedation (if applicable) have also been explained. The therapeutic alternatives to the operation and/or medical procedure and/or sedation (if applicable) and their risks and benefits have been explained. No warranty or guarantee has been made as to the result or cure.

Signature of Patient/Patient's Representative \_\_\_\_\_ Date 3/12/18 Time 1:35

Relationship of Representative to Patient \_\_\_\_\_ Resident Physician Providing Information (Signature)  M.D. 3/12/18  
Date \_\_\_\_\_

Resident Physician Providing Information (Printed Name) Go Katsuy

Signature of Witness or Interpreter \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Attending Physician (Signature)  M.D. 3/12/18 1:35  
Date \_\_\_\_\_ Time \_\_\_\_\_

Attending Physician (Printed Name) Kenneth Chang, MD

**SECTION III: EXCEPTIONAL SIGNATURE REQUIREMENTS ARE REFERENCED BELOW  
(please check appropriate box(es))**

1. If the patient is a MINOR, the parent or guardian must sign as "Patient's Representative" unless the patient is legally permitted to sign.
2. If the patient is LEGALLY INCOMPETENT, the court approved guardian or conservator must sign as the "Patient's Representative"
3. If the patient reads no English, Spanish, or Vietnamese, an interpreter shall read this form to the patient. The patient and the interpreter shall sign at the end of Section II and the interpreter shall indicate the language used: \_\_\_\_\_
4. If the patient is PHYSICALLY INCAPABLE OF SIGNING, then:
  - a. If the patient can make a mark, the patient should do so, witnessed by a University employee, or
  - b. If the patient is physically incapable of signing, a University employee, and when possible, the patient's spouse or next of kin, should sign in witness of the patient's having given verbal consent.In either case, an Employee-Witness or interpreter will sign as Witness and write in the reason in the space provided:  
\_\_\_\_\_
5. If the person having legal capacity to consent for the patient is not otherwise available, consent for medical or surgical treatment has been obtained by telephone. Note (telephonic) next to patient's representative's name.
6. THIS IS AN EMERGENCY. \_\_\_\_\_, M.D.