MedStar Georgetown
University Hospital

[redacted]

CONSENT FOR SURGERY, ANESTHETICS, AND OTHER MEDICAL SERVICES

1. I hereby authorize Dr.(s) Hawksworth (the [redacted]titioner(s)) and whomever he/she may designate as his/her assistants to perform upon [redacted] (patient name) the following surgical, medical or diagnostic procedure(s): (physician(s) to [redacted] the specific procedure to be performed) Robotic Liver Cyst Fenestration, Revision of Cerebral Spinal Fluid Shunt

2. I acknowledge that my physician(s) discussed with me the proposed care, treatment and services. I have been advised of the potential benefits, risks, side effects and likelihood of achieving goals. I also have been advised of any potential problems that might occur during recuperation. I have been advised of reasonable alternatives to proposed care, treatment, services and risks, benefits and side effects related to the alternative treatment and the risk related to not receiving the proposed care, treatment and services. I understand that in the course of the procedure the physician(s) may determine that procedures in addition or different from this procedure may be necessary to my well being and that it would not be practical to obtain further consent at the time. I therefore authorize the doctor(s) to perform such procedures without further consultation with me.
3. I have been provided information that in certain circumstances information about my care, treatment and services may be disclosed as required by law or regulation. Certain circumstances may include mandatory reporting requirements to the centers for Disease Control, health department or Food and Drug Administration.
4. My physician, the responsible physician(s), will be present for all critical parts of the procedure even in the event of overlapping procedures (see reverse, if applicable). Other medical professionals may perform some non-critical aspects of the procedure as my responsible physician deems appropriate. I understand that MedStar is a teaching organization. This means that resident doctors, doctors in medical fellowship (fellows) and students in medical, nursing and related health care professions receive training here, and may take part in my procedure, under the oversight and supervision of the responsible physician.
5. I also consent to the administration of anesthetics by or under the direction of the physician that has been trained to perform the required local anesthetic or moderate or deep sedation. The physician has explained the risks, benefits, side effects, and alternatives of the intended anesthesia.
6. For purposes of research, medical education or documentation of my medical condition in the medical record, I consent to the taking of photographs or films during the course of the procedure(s). I understand that my identity will not be revealed if the photographs or films are used for medical education or research, and in all instances patient confidentiality will be preserved. I understand that copies of the prints will be given to me if I ask for them.
7. I am aware that the practice of medicine and surgery is not an exact science, that there is no certainty that the desired benefits will be achieved and I acknowledge that no guarantees or assurances have been made to me concerning the outcome.

[redacted]	10/14/2020	0700	self
Patient or authorized representative signature	Date	Time	Relation to Patient
RN	10/14/2020	0708	
Witness signature	Date	Time	

VERBAL TELEPHONE CONSENT

(If authorized representative is not available to sign the above consent)

Authorized Representative Name — Relation to Patient

Signature of Physician/ Practitioner Obtaining Consent — Date — Time

Signature of Witness to Verbal Consent — Date — Time

❑ **NON-OR SAFE SURGERY CHECKLIST:**

Team Pause Date: ____________ Time: __________ Signature & Title ______________________________

❑ Patient receiving anticoagulation: ❑ Yes ❑ No — ❑ Coagulation abnormalities addressed: ❑ Yes ❑ No

❑ Correct Patient Identity — ❑ Agreement on Procedure to be Done.

❑ Correct Site & Side Marked: ❑ Left ❑ Right ❑ N/A

❑ Correct Patient Position — ❑ Availability of All Anticipated Equipment, Meds and/or Supplies

❑ Patient History Checked