



University of Missouri Health System

# CONSENT TO OPERATIVE, SPECIAL PROCEDURES AND BLOOD TRANSFUSIONS

VN: 37003703 ADM: 10/23/18 15:03  
MR: [REDACTED]  
UF: 20180407 DT: TMC RMT:

(Patient's name) [REDACTED] hereby authorizes (Physician(s)/practitioner(s)) [REDACTED] and whenever  
may be designated as assistants to perform the following: (operation or procedure) [REDACTED]

Moderate or deep sedation is planned for this procedure: ☒ Yes ☐ No General anesthesia is planned for this procedure: ☒ Yes ☐ No

- I understand the possible risks of this procedure to include, but are not limited to:  
Asking patient pain damage to nearby structures, need for additional surgery
- I understand the potential benefits of this procedure to include, but are not limited to:  
Diagnosis
- I was informed the possible alternatives include, but are not limited to:

Surge Consent-The procedure above will be performed an estimated \_\_\_\_\_ times ending on \_\_\_\_\_ (Date). The risks and benefits will not change throughout the entirety of the series. Patient acknowledges: \_\_\_\_\_ (Pt Initials).

- During my procedure I may be asleep (general anesthesia). If I have concerns or questions related to my anesthesia, I have the opportunity to discuss them in advance with my anesthesia provider. ☒ Yes ☐ No
- I authorize the administration of moderate sedation as deemed advisable by the physician(s)/practitioner(s) performing or assisting in the procedure. The risks, benefits, and alternatives of the moderate sedation as well as the types of moderate sedation have been explained to me and I fully understand my options. ☒ Yes ☐ No
- I acknowledge that no guarantee or assurance has been made to me of the results that may be obtained. ☒ Yes ☐ No
- I consent to have any tissue or parts removed during the procedure used for diagnostic purposes. ☒ Yes ☐ No
- In order to advance the understanding of medical education, research and other clinical activities, I consent to the admission of observers into the procedure room, and to the taking and publication of photographs or video clips, during the course of this procedure. ☒ Yes ☐ No
- I understand that my physician(s)/practitioner(s) will be immediately available for the entirety of my procedure and will be present in the OR for all key portions of my procedure. I understand that my physician(s)/practitioner(s) may participate in overlapping studies during the time I am in the OR. ☒ Yes ☐ No

- APPLICABLE USE FOR BLOOD TRANSFUSIONS (NON-OPERATIVE & OPERATIVE)**
- BLOOD TRANSFUSION:** I authorize the administration of blood/blood components as deemed necessary by the physician/practitioner for as often as may be needed. Potential complicating risks and alternatives have been explained. Including:
  - Occasional complications: Fever, chills, allergic reactions (such as hives), transmission of hepatitis virus without symptoms, transmission of infectious diseases unknown at this time.
  - Rare complications: Transmission of hepatitis with clinical symptoms and heart failure due to too much transfused fluid.
  - Very rare complications: Hemolysis (destruction of transfused red blood cells), transmission of infectious diseases besides hepatitis (including AIDS), shock, chest pain, and death.

**BLOOD REFUSAL:** I request that no blood or blood components or derivatives be administered during this hospitalization. I fully understand the possible consequences of refusal to permit blood transfusion.

## SIGNATURES REQUIRED

I HEREBY CONSENT TO THE PROCEDURE/TRANSFUSION OUTLINED ABOVE AND AUTHORIZE THE PHYSICIAN(S)/PRACTITIONER(S) LISTED TO PERFORM THIS PROCEDURE/TRANSFUSION. I CERTIFY AND ACKNOWLEDGE THAT I HAVE READ THIS FORM OR HAD IT READ TO ME, THAT I FULLY UNDERSTAND THE RISKS, BENEFITS, AND ALTERNATIVES AND THAT I HAD AMPLIFIED TO ASK QUESTIONS AND CONSIDER MY DECISION UPON YOUR AUTHORIZATION AND CONSENT. THIS OPERATION OR PROCEDURE TOGETHER WITH ANY DIFFERENT OR FURTHER PROCEDURES WHICH IN THE OPINION OF THE DOCTOR(S) PERFORMING THE PROCEDURE MAY BE INDICATED DUE TO ANY EMERGENCY OR AN UNFORSEEN CONDITION OF SUFFICIENT SEVERITY SUCH THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED TO RESULT IN SERIOUS IMPAIRMENT OR HARM TO THE HEALTH OR LIFE OF THE PATIENT. Patient Initials: \_\_\_\_\_

Date and Time \_\_\_\_\_ Signature of Patient \_\_\_\_\_

Date and Time \_\_\_\_\_ Signature of Clinician Present for Consent \_\_\_\_\_

Date and Time \_\_\_\_\_ Signature of Parent/Guardian or Witness \_\_\_\_\_

Relationship to Patient \_\_\_\_\_