HEALTH
UNIVERSITY OF UTAH

MRN [redacted] F DOB [redacted]
CSN [redacted] DOS [redacted]

CONSENT TO PERFORM HEALTH CARE PROCEDURES AND RELATED SERVICES

I. I authorize Dr. George Rafael, my health care provider, and/or such other
(Required: Print Provider Name)
University of Utah Health employees and trainees my provider designates, to perform or participate in the following health care procedures and any other medical treatment necessary for my well-being and safety as described Exploratory laparotomy and all indicated procedures
(Required, no abbreviations).

☐ Check if name of provider supplying consent information is the same as above.

Print name of provider providing information if different from above: [redacted]
(Required if different from above)

II. My provider has explained the nature of my medical condition and the nature and purpose of the health care procedures or treatments he/she is proposing. My provider has also explained alternative methods of treatment, the risks of those treatments, and what could happen if I do not receive any treatment. I have been able to ask questions about the health care procedures and the alternatives to treatment. My provider has answered my questions. I understand the risks involved and I voluntarily assume the risks in the hopes of obtaining the desired beneficial results.

III. My medical team may use local anesthesia *(numbing medicine)* to help decrease my pain.
Additional anesthesia/sedation will be the responsibility of ***(check one if applicable)***

☒ the department of anesthesiology *(a separate informed consent form will be provided)*

– OR –

☐ the person performing my procedure or another privileged provider. My health care provider has described the proposed anesthesia/sedation and also explained the risks, benefits, and alternative methods (if any) of anesthesia/sedation. My provider has answered all of my related questions. I understand the risks involved and assume the risks in hopes of obtaining the desired beneficial results. My anesthesia/sedation is anticipated to involve: ***(check one if applicable)***

☐ Moderate sedation *(by privileged moderate sedation provider)*
☐ Deep sedation *(by privileged deep sedation provider)*

Name of provider providing sedation if different than the provider performing the procedure:

_____ ***(Document if applicable)***

IV. I have been informed that I may need a transfusion of blood and/or a blood product in the course of my treatment. My provider has explained the important risks of blood or a blood product, and the alternatives of a blood transfusion, including the risks of not receiving blood or a blood product. I consent to receiving blood or blood products if my provider decides that it is medically necessary for my well-being and safety. **Required: Patient Initial YES or NO or Provider initial not applicable**

YES [redacted] *(Patient initial)* **NO** ____ *(Patient initial)* **Not Applicable** ____ *(Provider initial as needed)*

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V. I understand the University of Utah Health may dispose of or potentially use for any purpose any tissues that may be removed.

VI. I understand that among those who attend to patients are medical, nursing, and other health care personnel in training who may be present or provide patient care as part of their education. This is also covered in the admission conditional agreement.

VII. I understand that closed circuit television, the taking of photographs and motion pictures, drawings and similar graphic material for the purpose of advancing medical knowledge may be used. I understand that my identity will not be revealed unless I agree in a separate document to be identified.

VIII. If I am receiving surgery, my surgeon will be present for the critical or key portion of the procedure until the point at which my surgeon determines that his/her expertise is no longer necessary. Other qualified practitioners, which may include other attending providers, advanced practice clinicians, fellows and residents, will be involved with my care, and if they are involved, they will be directly supervised, or will be allowed to independently perform portions of my care, including opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues, under the direction of my surgeon if determined they are qualified to have that responsibility. Before or after the critical or key portion of my surgery, my surgeon may not be in the operating room but will be immediately available.

IX. Additional Notes: _____

Required: Signature of Patient **or** (Legally Authorized Person) [redacted]

Required: Printed Name of Patient **or** (Legally Authorized Person) [redacted]

(Relationship to Patient) [redacted]

Required: Provider/Staff Witnessing Signature of Patient: [redacted]

Consent obtained if by telephone: _____ (Witness initial if yes)

Required: Dated this [redacted] day of [redacted]. **Required: Time:** 09:25