Printed by [redacted]

Name: [redacted] MRN: [redacted]

CSN [redacted]

[redacted]

Medical Re AKA:
DOB [redacted] MRN: [redacted] Sex:F
HAR ADM

[redacted]

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

**CONSENT • CONSENT TO OPERATION, PROCEDURE AND ADMINISTRATION OF ANESTHESIA**



10. I authorize Fournator

**NAME OF PHYSICIAN / PRACTITIONER performing procedure**

to perform the following **OPERATION OR PROCEDURE:** *[Spell out all words. Do not abbreviate. Identify side/level of procedure to be performed if applicable.]*

exploratory laparotomy, possible bowel resection and anastomosis

11. **By my signature below, I confirm that:**
    - I have read, understand and agree to the above;
    - My physician has provided me with information to make a fully informed decision to undergo the operation or procedure documented above; and
    - I consent to the performance of the operation or procedure.

[redacted] [redacted] [redacted]

DATE TIME SIGNATURE (Patient /Legal Designated Representative)

[redacted] self

PRINT NAME RELATIONSHIP TO PATIENT

12. If an interpreter participated in the informed consent discussion:

Print Interpreter Name & ID# or Agency Name Telephone Interpreter ID#

**TELEPHONE CONSENT:** (Applies *only* if the legal designated representative is not physically present to sign this form*).

DATE TIME SIGNATURE NAME OF WITNESS/HOSPITAL EMPLOYEE PRINT NAME

**Witness/hospital employee (ex: resident, RN, NP, PA) must:*

*1) witness the informed consent telephone discussion between the legal designated representative and the attending physician or other health care provider credentialed to perform the procedure or surgery; and*

*2) affirm that the legal designated representative consented to the procedure.*

Printed by [redacted]

Name: [redacted] MRN: [redacted]

CSN [redacted]

DOB [redacted] MRN [redacted] Sex:F

HAR [redacted] ADM [redacted]

[redacted]

Medical Record Number

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

[redacted]

**CONSENT • CONSENT TO OPERATION, PROCEDURE AND ADMINISTRATION OF ANESTHESIA**



**PLEASE READ THE ENTIRE FORM CAREFULLY BEFORE SIGNING.**

1. I understand that any operation or procedure may involve the risk of an unsuccessful result or complication, including but not limited to bleeding, infection, nerve/nervous system damage, injury to organs/structures, or even death from both known and unforeseen causes.

2. My physician has explained to me the nature and purpose of the operation or procedure along with the risks, benefits and alternatives of the procedure to my satisfaction. In addition, the risks and benefits of these alternatives, and the risks of having no treatment have been explained to me. I have had the opportunity to ask questions and have received all the information I desire about the operation or procedure. Except in an emergency, I understand that an operation or procedure is not performed until I have had the opportunity to receive this information and have given my consent. In an emergency, I understand there may be different or further procedures required if the physician believes they are necessary and I consent to such procedures.

3. I understand that the administration of anesthesia and/or moderate sedation may be necessary to assure safety and comfort during the procedure and I consent to the administration if indicated. I understand that certain risks and complications may be associated with the use of anesthesia and/or moderate sedation and the physician has discussed these risks with me prior to the procedure.

4. I understand that the operation or procedure may involve the use of a Food and Drug Administration (FDA) approved drug or device for a purpose not approved by the FDA. I understand that other medical care will not be withheld if I decide to withhold or withdraw my consent to this proposed treatment.

5. I understand that Stanford Health Care (SHC) is an educational institution and as part of the medical education and training program, postgraduate fellows, residents, medical students, surgical assistants, approved health care practitioners and visiting professors may observe care, and if appropriately trained, participate in aspects of the operation or procedure under the supervision of my physician.

6. If applicable, my physician has informed me of the potential for an overlapping surgery. I understand that my physician will be present during key or critical portions of my procedure or surgery and in some circumstances, my physician may participate in another operation following the key or critical portions of my surgery. In this circumstance, my physician will be immediately available or will ensure another qualified physician is immediately available.

7. I understand that if the procedure involves specialized equipment or medical device(s), the manufacturer's representative(s) may be present during the procedure to assist in the selection or calibration of the equipment or device(s) and in the related treatment.

8. I consent to the hospital's use and/or disposal, at its discretion, of any blood, bodily fluid, member, organ, or other tissue removed or obtained during the operation or procedure for research that may be conducted by SHC, Stanford University or unaffiliated academic or commercial third parties if allowed under legal requirements and relevant policies.

9. I consent to the taking of pictures, videotapes or other electronic reproductions of my medical or surgical condition or treatment, and the use of the pictures or videotapes for treatment or internal or external activities consistent with SHC's mission, such as education and research, conducted in accordance with Hospital policies.