SHARED ELECTRONIC HEALTH RECORD

CONSENT
2 0 0 0

Patient Name: _____

MRN: _____ DOB: _____

Treatment Location: _____

SURGICAL AND MEDICAL PROCEDURES AND BLOOD TRANSFUSION

I, as the Patient, hereby give consent to and authorize Dr._____and their assistant(s), who may include supervised physicians in residency training, to perform the following surgical or medical procedures and related tasks, tests, and treatment on me, including dissecting tissue, removing tissue, and retaining for research and teaching purposes tissue and specimens that would be otherwise discarded, harvesting grafts, blood transfusion, and related medical treatment, and specifically including the following surgical or medical procedure(s): exploratory laparotomy, possible bowel resection, possible ostomy, any other indicated procedures - SERIAL CONSENT

I further consent to such additional procedures or treatment as are considered advisable based on findings during the above described surgical or medical procedure(s). The physician(s) performing the surgical or medical procedure(s) or designee has explained to me: (1) nature and purpose; (2) the expected benefits; and (3) the usual and most frequent risks and hazards with such surgical and medical procedure(s) which may be affected by my particular co-morbidities, including the following:

bleeding, infection, damage to surrounding structures, need for future procedures / surgery, heart attack, stroke, death

The physician performing the procedure(s) or designee has explained to me the risks and benefits of any reasonable alternatives to the proposed surgical and medical procedure(s) and the risks and benefits of refusing the proposed surgical and medical procedure(s). Other risks such as severe blood loss, infection, and cardiac arrest exist even with proper care in any such surgical and medical procedure(s).

I understand that some medical care will be provided by physicians and others employed by the hospital; some care may be provided by physicians in their private practice. Anesthesiology, radiology, and pathology services and many other medical specialty services are provided by physicians and other clinicians who are not employed by MaineHealth but are authorized to provide care at the hospital as members of their private practices. My primary care physician and my treating physicians can explain on request my options for selecting treating physicians at the hospital or another facility. I understand that the hospital is a teaching hospital and authorized physicians and trainees may observe or assist in diagnosis and treatment. Images may be made to share with consulting physicians or for research and teaching while using reasonable efforts to avoid identifying me. **Do not use my images for teaching or research** ❑

Exam under Anesthesia. A standard part of the procedure being performed includes a ❑pelvic exam, ❑rectal exam, ❑prostate exam, or ❑ _____ (identify body part) for diagnostic purposes, and is medically necessary, I hereby consent to and authorize the examination by my physician and designated trainees. **Not Applicable** ❑ **DECLINE above exam** ❑

Blood Products: I understand that the transfusion of blood components (red cells, plasma, platelets, cryoprecipitate, serum) may be necessary or appropriate as part of my care, or to treat conditions arising from this surgical or medical procedure(s). Mild reactions such as fever and hives are quite common. Despite testing, the risk of an extremely rare but serious reaction or infection exists, including HIV, hepatitis, lung injury, and death. Under some clinical situations and with appropriate planning, alternatives to transfusion may be considered. Additional discussion of the risks and alternatives has been offered. The risks of refusing this transfusion have been fully explained to me by the physician performing the procedure(s) or designee, and I fully understand such risks could include death. I hereby consent to the above described surgical or medical procedure(s), **AND** Blood Products **UNLESS** the "DECLINE Blood Products" box is checked. **DECLINE Blood Products** ❑

Company Representative: I have been informed a company representative may observe the surgical or medical procedure(s) to provide technical information or gain knowledge useful in the development of medical devices. The representatives will not "scrub" or use devices but will have minimal information about me. I hereby consent to the presence of the representative UNLESS the "Decline presence" box is checked. **Not Applicable** ❑ **DECLINE Representative Presence** ❑

I understand that I have the right to refuse any suggested surgical or medical procedure(s) or treatment. I further understand that the practice of medicine is not an exact science, and practitioners cannot guarantee results. No guarantees have been made to me concerning the results of the proposed procedure(s) or treatment.

I acknowledge that I have read this form, that I understand the nature and purpose of the surgical or medical procedure(s), benefits and risks, alternatives and expected results of the services planned for me, and that I have had ample time to ask questions and to consider my decision.

Date	Time AM|PM	X Signature ❑ Patient ❑ Parent ❑ Guardian ❑ Authorized Representative	Printed Name

If by telephone consent given by: ❑ Patient ❑ Other _____ Phone number _____

Date	Time AM|PM	X Witness Signature (For phone consent or when patient is physically unable to sign)	Printed Name

Interpreter for: ❑ Sign Language ❑ Foreign Language ❑ Other _____ Print Name or identifying information _____

Date	Time 24 Hour	X Signature of Physician or Designee	Printed Name