ASPIRUS™
Passion for excellence.
Compassion for people.

STATEMENT OF INFORMED CONSENT

Clear Form

Wausau, WI or _____

PATIENT'S NAME: _____

Operative and Other Procedures *(Address Laterality in the description)*

I hereby authorize and direct _____ and/or associates or assistants to perform the following operation, treatment, care, and/or procedure(s):

_____

_____

_____

_____

_____

_____

_____

☐ **Sedation/Analgesia provided by other than Anesthesia Services (For local sedation)**
I consent to the administration of sedation/analgesia as prescribed by the practitioner prior to the procedure.

☐ **Administration of Blood/Blood Products**
I consent to the administration of Blood/Blood Products as prescribed by the practitioner as related to this episode of care.

By signing below, I acknowledge that I have read and fully understand the information on both sides of this form. I also acknowledge that my practitioner and or associates have adequately informed me of the following:

- The proposed care, treatment and services
- The potential benefits, risks, and side effects of the proposed care/treatment, the likelihood of achieving the goals of the proposed care/treatment, and potential problems that may occur during recuperation.
- The reasonable alternatives to the proposed care/treatment, including the risks, benefits, and side effects related to the alternatives, and the risks of not receiving the proposed care/treatment.
- Circumstances under which information must be disclosed or reported. (For example, cases of HIV, tuberculosis, viral meningitis or other diseases must be reported to the Health Department or Centers for Disease Control.)

I have had an opportunity to ask questions and all of my concerns have been addressed to my satisfaction. I hereby give authorization to proceed.

Authorizing Signatures

Patient's Signature _____ Date _____ Time _____

Witness to Signature _____ Date _____ Time _____

Interpreter Signature (if applicable) _____ Date _____ Time _____

If the patient is a minor, has a guardian, is unable to sign or this is a telephone consent:

Patient unable to sign because _____

Person signing **or** giving phone consent:_____ Date _____ Time _____

Relationship to patient: _____

Witness (1)_____ Date _____ Time _____

Witness (2) _____ Date _____ Time _____

(2nd witness required for telephone consent)

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STATEMENT OF INFORMED CONSENT

patient label

Wausau, WI or _____

OPERATIVE AND OTHER PROCEDURES

I have been informed of the nature and purpose of the proposed procedure(s), the risks of the proposed procedure(s), the possible or likely consequences of the proposed procedure(s), available alternative treatments, and the likely outcome if no treatment is received. I understand the risk of complications, serious injury or even death which may result from known and unknown causes. I am aware that any surgical procedure may carry the risk of: severe blood loss requiring the administration of blood products, infection, cardiac arrest, or other untoward event. I am also aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment(s).

I acknowledge that unforeseen circumstances may arise during the performance of the operation or procedure. I consent to the performance of any additional or different procedures than the one explained to me if it is felt to be necessary.

I authorize the Hospital to dispose of any tissue or body parts which may be removed from me.

I consent to the taking and publication of any photographs in the course of this operation, treatment and/or procedure for the purpose of advancing medical education.

If I receive an implantable medical device, I understand that my name and social security number will be provided to the manufacturer of the device as required by the Safe Medical Device Act of 1990.

ANESTHESIA

Anesthesia involves medications and supportive care which are provided by an anesthesiologist or nurse anesthetist during the course of the proposed procedure. These medications are given to eliminate sensation and may render me unconscious or unaware of my surroundings. I understand that the administration of anesthesia involves the risk of complications, serious injury and even death. Consent for anesthesia will be discussed with you by the anesthesiologist or nurse anesthetist prior to the procedure.

SEDATION/ANALGESIA

Medications that are given to make me feel sleepy, relaxed, and comfortable during the procedure. There is a slight risk that the sedation will depress my breathing drive, if this happens, I will need help to breathe.

ADMINISTRATION OF BLOOD AND/OR BLOOD PRODUCTS

I have been informed that as a patient I may require blood and/or blood product transfusions during the course of my treatment.

I understand that the blood and/or blood products, such as platelets, are given into a vein (intravenously/IV) over a specified period of time. The type, amount and frequency of blood/blood products given or transfused will be determined by my physician based on my needs.

I understand that minor and transient reactions to transfusion can occur such as hives, chills, fever or nausea.

I understand that before blood is transfused, the lab mixes (cross matches) a sample of blood with a sample of the donor's blood to be certain they are compatible. The tests markedly decrease the chance of adverse reaction to transfusion, but are not able to completely prevent them. Every effort is made to make sure that the blood products are as safe as possible.

I understand the chance of getting a disease from transfused blood is extremely small. Infectious diseases which are known to be transmitted by blood include TAVH (transfusion associated viral hepatitis) a viral infection of the liver, and HIV (human immunodeficiency virus), the virus that causes Acquired Immunodeficiency Syndrome (AIDS). Blood products are tested to avoid TAVH and HIV. These laboratory tests are very reliable but not absolutely foolproof.