WhidbeyHealth

WhidbeyHealth Medical Center
101 N. Main St, Coupeville, WA 98239
360-678-5151 • 360-321-5151
www.whidbeyhealth.org

GENERAL CONSENT FOR SURGERY OR INVASIVE PROCEDURE

PROCEDURE DESCRIPTION: _____

_____

INDICATIONS: _____

_____

BENEFITS: My practitioner has discussed with me the possible benefits associated with this procedure. I understand that there is no certainty that I will achieve these benefits. No guarantee(s) has/have been made to me regarding the outcome of this procedure.

ALTERNATIVES: Reasonable alternative(s) to this procedure, including no procedure, have been explained to me by my practitioner. He/she discussed the risks and benefits of not having the procedure.

RISKS: My practitioner has discussed with me specific risks associated with this procedure. If these risks occur, their treatment may require additional procedures. I understand that the common risks with any procedure include but are not limited to stroke, device failure, infection, nerve injury, blood clots, heart attack, allergic reactions, respiratory failure, kidney failure, bleeding, and severe blood loss. These risks can be serious and possibly fatal. I understand and freely assume these risks. If used, the risks and side effects associated with anesthesia or sedation will be discussed with me before I have my procedure. I will be asked to sign a separate consent regarding anesthesia or sedation prior to my procedure.

CARE TEAM: I expect the involvement of a care team which may include anesthesia providers, nurses, technicians, medical device specialists, other attending surgeons, residents, fellows, medical students, or other allied healthcare professionals. At my practitioner's discretion I authorize such associates or assistants to perform portions of the operation or procedure. My practitioner may allow observers during my procedure. They are not part of the care team and will not participate in providing care.

PRESENCE IN OPERATING ROOM: Key and/or critical portions of the procedure will be performed by my practitioner or by a similarly qualified practitioner. Other portions of the procedure may involve contributions by additional providers.

BLOOD TRANSFUSION: My practitioner and I have discussed the potential for blood transfusion related to this procedure and my preference regarding transfusion. If blood product transfusion is anticipated, additional documentation/consent will be completed.

PATHOLOGY: I accept that any specimens, such as tissue, blood, bodily fluids, etc., may be examined, disposed of, or stored for future use in medical studies or research. Any research involving specimens will be reviewed by an appropriate review board. I understand that my tissue or other explanted material will not be returned to me.

VIDEO or PHOTOGRAPHY RECORD: I understand video or photography records made as part of my treatment and/or diagnosis may be useful for clinical education or professional publications. If used in this way, I understand that my records will be edited so that I will not be, and cannot be, identified. Video or photography records will not be used for any other purpose without my authorization.

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PRACTITIONER'S STATEMENT: I have explained the contents of this document to the patient/legal representative and have answered all the patient's questions, and to the best of my knowledge, I feel this patient is competent, has been adequately informed, and is not acting under duress.

Practitioner's Signature | Printed Name | Date | Time

PATIENT'S STATEMENT: My practitioner has discussed this with me, and I understand what will be involved with my procedure including the fact that I may receive either anesthesia or sedation, or both. I understand my rights and responsibilities to make decisions about my healthcare. I may have received additional education material. Any questions I have had regarding this procedure have been answered to my satisfaction. I have made my decision voluntarily and freely. Therefore, I authorize my practitioner _____ [Practitioner's name], to perform this procedure.

Patient's Signature (or legal representative) | Printed Name | Date | Time

Relationship (if other than patient): _____

WITNESS' STATEMENT: By signing below I affirm that the patient is competent, has received informed consent for the procedure, and has no additional questions.

Witness' Signature | Printed Name | Date | Time

□ Yes – Interpreter was used as part of this process.
Interpreters name ID number, and language: _____

If the date of consent is greater than 90 days either a new consent form or affirmation of the consent is required.

☐ **I affirm that this GENERAL CONSENT FOR SURGERY OR INVASIVE PROCEDURE is still accurate and as written. No revisions are necessary.**

Patient's Signature (or legal representative) | Practitioner's Signature | Date | Time

Day of the Procedure

Patient confirms that they wish to proceed with the above procedure with full understanding of the potential risks, benefits, and alternatives.

RN/Tech signature: _____ Date: _____ Time: _____

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