Patient Name

DOB:

MR #

Index to Consent – Treatment/Procedures

Date: _____

Madison Surgery Center
1 S. Park Street-3rd Floor Madison, WI 53715

CONSENT TO OPERATIONS, ANESTHETICS, DIAGNOSTIC RADIOLOGY, TRANSFUSION, OR OTHER PROCEDURES

I request and allow Dr. _____, and/or other doctors, assistants, students, and staff who may be assigned to my care, to perform on: _____ the following:
(Patient's name or "Myself")

_____

_____

When the procedure is planned for one side of the body, check the planned side here: ☐ RIGHT ☐ LEFT

I have read page 2 of this form and have crossed out, limited, or made the following changes: _____

_____

By signing, I confirm that (1) I have read **both pages of this form**, (2) I understand the form and information given to me by my doctor or doctor's designee, (3) I have had the chance to ask questions and have had them answered to my liking, and (4) I give my consent to perform the operation(s) or procedure(s) listed above. The risks, benefits, and other options have been explained to me. The risks of not having the procedure have also been explained to me and I agree to proceed.

AUTHORIZING SIGNATURES:

Signature of Patient/Representative _____ Date: _____ Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

Patient is: □ Minor □ Incompetent / Incapacitated
Legal Authority: □ Legal Guardian □ Parent of Minor
□ Health Care Agent □ Other _____

Physician Signature: _____ Print Physician Name: _____

Date: _____ Time: _____ Pager# _____

_____ _____
Interpreter or Reader Signature (if applicable) Witness Signature (if applicable)

_____ _____
Print Interpreter or Reader Name Print Witness Name

_____ _____
Date Time Date Time

Patient Name

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A doctor has fully explained to me:

- the nature and concerns of the procedure(s)
- other options for treatment
- possible outcomes
- what may happen if I do not get treated
- risks such as severe loss of blood, infection, and cardiac arrest, that can happen during any procedure.

I understand the risk of problems, serious injury or even death that may result from both known and unknown causes.

I understand/have been told that:

1. Before, during, or after the procedure listed above, I may develop or the doctor may find new problems that could not be foreseen. These findings may require that more or different procedures be used. I request and allow my doctors to use the procedures they feel are best to care for me.
2. I may get an anesthetic from a member of the Department of Anesthesiology, a resident, a nurse, or the operating surgeon. My options and the risks/benefits of its use have been made clear to me. I consent to the use of such anesthesia. Restrictions, if any, on the type of anesthetic are noted on page 1 of this form.
3. I understand that blood loss is a risk of the procedure. The benefits, risks and alternatives associated with blood product transfusions have been explained to me, as well as the risks of refusing such transfusions. I understand that the blood products have been tested for hepatitis, HIV (the cause of AIDS), as well as other pathogens including West Nile Virus. Blood products may or may not have been tested for bacteria before you receive them. Testing greatly reduces, but does not eliminate the possibility that you (the patient) may get these or other infections from a blood transfusion. Other occasional complications include allergic reactions such as hives, chills, fever, and nausea. Other infrequent complications include rapid destruction of transfused blood, fluid excess in the lung, shock, and severe allergic reactions. I acknowledge and understand that this facility may decide, based on my care needs, to transport me to a hospital or other facility if blood product transfusions are needed.
4. I understand that it is the practice at this surgery center and the physicians providing my care to temporarily suspend “do not resuscitate” (DNR) orders and I agree to such suspension.
5. The independent practitioners who have been granted the privilege of using this facility for the care and treatment of patients are not employees or agents of the surgery center. The University of Wisconsin Hospitals and Clinics and its medical staff have service, educational, and research relationships with the University of Wisconsin Madison and other affiliated health care, service and educational institutions. The physicians involved in the care are comprised of medical staff members on the University faculty, residents or fellows in training programs.
6. The practice of medicine, surgery and dentistry is not an exact science. No promises have been made to me about the results of the procedure(s).
7. I consent to have any of the procedure(s) observed, photographed, filmed, televised, or recorded to help improve health care, education or knowledge. I understand that my identity will not be made known by the pictures.
8. I consent to this surgery center keeping or throwing away any tissue or body parts removed during the procedure(s), and for these to be used for research.
9. There may be a need to share or report information about me (the patient), such as HIV, tuberculosis, and other diseases to places such as the state health department.