SHARED ELECTRONIC HEALTH RECORD

CONSENT
2 0 0 0

SURGICAL AND MEDICAL TREATMENT AND BLOOD TRANSFUSION

Patient Name: _____

MRN: _____ DOB: _____

Treatment Location: _____

I, as the Patient, hereby give consent to and authorize Dr._____and his/her assistant(s), who may include supervised physicians in residency training, to perform surgery, or other 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 procedures:

laparoscopic appendectomy, possible open

This consent extends to such additional procedures or treatment considered advisable from findings made during this procedure. The physician(s) performing the procedure or another speaking for him or her has explained to me: (1) the purpose, (2) the expected benefits, and (3) the usual and most frequent risks and hazards with such procedures and treatment, including the following:

bleeding, infection, damage to surrounding structures, need for future procedures / surgery, abscess

They also have explained to me any reasonable alternative procedures or treatment and the usual and most frequent risks and hazards of such alternatives. Other risks such as severe blood loss, infection and cardiac arrest exist even with proper care in any such procedures or treatment.

Medical science cannot produce guaranteed results and no guarantees have been made to me concerning the results of this procedure. 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 own 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 own private practices. My primary care physician and my treating physicians can explain on request my options for selecting treating physicians at the hospital or at 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 make images of me for teaching or research ❑

Blood Products: I understand that the transfusion of blood components (red cells, plasma, platelets, cryoprecipitate) may be necessary or appropriate as part of my care, or to treat conditions arising from this surgery or other procedures. 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.

I hereby consent to surgery, treatment, **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 procedure 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 ❑**

X _____ _____ AM|PM X _____

Signature of ❑ Patient ❑ Parent ❑ Guardian ❑ Authorized Representative | Date | Time | Witness Signature

Printed name of person signing on behalf of the patient: _____ Patient is a ❑ Minor or _____

Consent given by telephone ❑ Patient ❑ Other _____ Telephone #_____

Printed name of interpreter _____ Reason ❑ Sign ❑ Language ❑ Other _____

X _____ _____ _____ _____

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