MaineHealth

SHARED ELECTRONIC HEALTH RECORD

146051

Patient Name: _____

Date of Birth: _____

CONSENT FOR SURGICAL AND MEDICAL TREATMENT AND BLOOD TRANSFUSION

I, as the Patient, hereby give consent to and authorize Dr. _____ and his/her assistant(s), including 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: **Suprapubic Cystostomy Tube Insertion.**

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: **Infection (similar to urethral catheter), Bleeding, Pain, Injury to bowel or urinary tract, Leakage of urine per urethra, Need for ongoing catheter, Maintain tube for no less than 6 weeks, Surgical positioning injuries.**

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 MMC 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 during this hospital stay. 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 representative 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. **DECLINE Representative presence** ☐

If the patient is a minor or is unable to give informed consent, the following must be completed:

The patient is unable to give consent because: _____minor; Other: _____

The person representing the patient does so in what capacity/ is what relation to the patient:

_____ Parent _____Spouse _____ Legal representative; Other: _____

Name of person representing patient: _____

Signature of Patient or Patient Representative: _____ **Date:**_____

If consent is obtained by telephone: Name of person giving telephonic consent: ☐ Patient ☐ Other: _____

Signature of witness: _____

If interpreter is used in consent process, name of interpreter: _____

Reason: ____ Disabled ____ Language other than English; Other reason: _____

Signature of Physician or Designee:_____ **Date:** _____ **24-h Time:** _____