INFORMED CONSENT FOR OPERATION OR PROCEDURE

Print Patient Name _____ **Patient's Date of Birth** _____

I authorize _____ to perform the following procedure: *(NO ABBREVIATIONS/ACRONYMS)*
___ *Right* ___ *Left* ___ *NA* _____

_____

_____

I understand the reason for the procedure is: _____

_____

No guarantee or assurance has been made to me as to the results of the procedure.
I also authorize any additional procedures deemed necessary due to unsuspected conditions found during the procedure.

ALTERNATIVES: _____

RISKS: Any procedure involves some risks and hazards. The most common risks of surgery include infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, pneumonia or death. Additional risks of this procedure include but are not limited to: _____

_____

- Administration of anesthesia involves risks, most importantly a rare risk of reaction to medication causing death. I consent to the use of such anesthetics as may be considered necessary by the anesthesiologist responsible for these services. I understand these and other related risks of anesthesia will be discussed with me by the anesthesiologist.
- I authorize other healthcare practitioners/healthcare students to perform important tasks in my procedure (i.e. opening, closing, removing tissue) based on their scope of practice under the direct supervision of my physician.
- Medical observation of my procedure may occur by healthcare team members, other healthcare students and designated sales representatives under the direct supervision of my physician.
- Any tissue or hardware removed will be disposed of or preserved safely by the hospital.
- The hospital will release applicable health information to device manufacturer(s) per state and/or federal regulations in order to track any implanted device in case of a recall or failure.
- Photographing/videotaping may be done for the purpose of diagnosis and/or treatment as determined by my physician.

A. ___ **NA** ___ **I agree** __ **I do not agree** to authorize healthcare student(s) to participate in my procedure
B. *Moderate sedation*: ___ **NA** ___ **I agree** ___ **I do not agree** to the use of moderate sedation based on the explanations of the risks, benefits and expected results of this type of sedation. ___ **Per Anesthesia recommendation**
C. *Allograft/xenograft*: ___ **NA** ___ **I agree** ___ **I do not agree** to the use of allograft/xenograft based on the explanations of the risks, benefits and expected results of its use. (See information sheet)
D. *Blood transfusion*: ___ **NA** ___ **I agree** ___ **I do not agree** to the use of blood or blood products during and after the procedure as needed based on the explanations of the risks, benefits and expected results (See information sheet)

PATIENT CONSENT: I have read and fully understand this consent form and the information my physician/LIP gave me. I understand that I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction or if I do not understand any of the words contained in this form.

Signature of Patient or Legal Representative: _____ Time: _____ Date: _____
Relationship to Patient: _____

PHYSICIAN/DENTIST/ LIP DECLARATION: I have explained the operation/procedure, anticipated benefits indications, alternatives, and material risks pertinent to this procedure. I have answered my patient's questions. The patient has been adequately informed and has consented.
Signature of Physician or LIP:_____ Time: _____ Date: _____

INTERPRETATION: □ Form □ Informed consent discussion interpreted for patient /representative by_____
□ Declined primary language consent

NA = Not Applicable

UNIVERSITY of COLORADO HEALTH
MEMORIAL HOSPITAL
1400 East Boulder Street
Colorado Springs, CO 80909

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This Consent is available in Spanish and the content is identical.

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Patient Information Sheet for Consent for Allograft / Xenograft

Allograft/xenograft is a bone or tissue product developed from human or animal sources. There are possible risks with implanting these types of products. Risks include reactions to the bone/tissue and infections such as hepatitis and HIV. These risks can be serious and possibly fatal.

Patient Information Sheet for Consent for Blood Transfusion

Procedure: In the course of your care, you may need a transfusion of blood and or one of its products. These transfusions may include whole blood, red blood cells, fresh frozen plasma, platelets, or cryoprecipitate.

Risks: The risks of blood transfusion include serious allergic reactions and reactions that can damage your own blood cells. Infections such as viral hepatitis and human immunodeficiency virus (HIV), a viral infection that causes acquired immunodeficiency syndrome (AIDS), can be transmitted with transfusions. The chance of transmitting infection is considered to be less than one in a million transfusions. These risks can be serious and possibly fatal.

Alternatives: The risks of **NOT** receiving blood far outweigh the risks of a transfusion. Additional options for your specific procedure may include pre-donation of your own blood (autologous blood donation) or the use of cell saver during surgery. If you refuse blood or blood products (donated, autologous, or use of cell saver), the risks may include organ damage from inadequate oxygen supply, inability to control bleeding, and sometimes death.

Additional Educational Information

☐ **See Attached Document for Additional Education**

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