St. Cloud Surgical Center

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CONSENT FOR SURGERY AND/OR INVASIVE PROCEDURES

1. I Agree that I will have:

a.	(surgery/procedure)
	(Procedure as scheduled)
b.	The reason for this procedure is: [patient's medical condition]:

My doctor may have help from others. Help could include opening and closing the wound. Help might also include taking grafts, cutting out tissue, implanting devices. I have been told who will help, if known.

2. I have talked to my doctor or health care team about:

- a. What the procedure is and what will happen.
- b. How it may help me (the benefits).
- c. How it might harm me (the most likely and most serious risks).
- d. The long-term effects it might have.
- e. My other choices for treatment. The risks and benefits of these choices.
- f. What will likely happen if I say no to this procedure.
- g. How I might feel right after and how quickly I can expect to recover.
- h. What medicines will be used to manage pain or sedate me.
- i. The plan for anesthesia.

<u>Note</u>: If this procedure is for removal of the uterus (hysterectomy), I know that this will prevent future pregnancies.

3. I agree that: (IF I DO NOT AGREE WITH A STATEMENT, I HAVE CROSSED IT OUT.)

- a. I will ask questions
- b. No one has promised me definite results for this procedure.
- c. If it is best for me, my doctor may change my treatment if they find further serious problems during this procedure.
- d. If I have "do not resuscitate" (DNR) wishes, they will be put on hold during the procedure.
- e. Students and others may watch the procedure. This must be approved by this facility.
- f. Pictures or video may be taken. They may be used for medical and/or learning reasons only.
- g. Tissues or items removed from my body may be tested. They will be disposed of with respect. Unless I agree, tissues will not be used for research or sold.
- h. If anyone is exposed to my blood or body fluids, my blood will be drawn and tested for HIV and hepatitis. The test results will go:
 - To me:
 - In my medical record;
 - To the exposed person. This is to be decided if treatment for the worker is needed;
 - To the Employee Health Services Department and/or Infection Control at this facility; and
 - To Minnesota health officials.

Blood transfusions:

I have been told how likely I am to need a blood transfusion. I know the risks and benefits of transfusions and if transfusions are needed, I give my consent to receive them. My doctor and I talked about my other options.

4. I understand that:

- a. I can change my mind. If I do, I must tell my doctor or team.
- b. The assisting staff, not surgeon, may change during the procedure.
 c. The team will double-check who I am. They will ask what I am having done. This is to protect me.

	authorized decision maker): have been answered. I agree to the proc	edure. Special instructions are wri	tten below:
Signature:	Patient's (or representative) signature	Date	Time
Reason if pat	ient unable to sign:		
representativ	sed the procedure and the information sta e) and answered their questions. The pati		
Signature:	Provider Signature other signature required if provider witnesses signature)	Date	Time
WITNESS: I have verified before the pro	d that the signature is that of the patient's ocedure.	or representative's. This form has	been signed
Signature:	Witness	Date	Time
		Date	TITIC
Signature:	Interpreter Name (please print)	Language/Organization	Time
For patients As part of I understate for me/pe My doctor harm to m They will of	of size exceeding 350 pounds: this procedure, I know that radiology and and that there may be limits to the use of the rsons of size. and staff will use their judgment about the	nis equipment or that it may not be use of this equipment to reduce	
		Patient/Witness Initials	S:
To be compl	eted at the time of admission to St. Clo	oud Surgical Center:	
Escort			
	cort		
Phone			

Surgeon may speak with Escort: Y N