1. **PROCEDURE:** I _____ *[Patient's name],* give consent to the following procedure(s):

_____

_____

_____ *[Description of procedure(s)].*

My practitioner has discussed with me and I understand what will be involved with my procedure including the fact that I may receive either anesthesia or sedation, or both. I understand my rights and responsibilities to make decisions about my healthcare. I may have received additional education material. I have made my decision voluntarily and freely.

Day of Procedure
Verify patient consents to the documented procedure.
RN/Tech initials _____
Date _____
Time _____

2. **RISKS:** My practitioner has discussed with me specific risks associated with this procedure. If these risks occur, their treatment may require additional procedures. I understand that the common risks with any procedure include but are not limited to: stroke, device failure, infection, nerve injury, blood clots, heart attack, allergic reactions, respiratory failure, kidney failure, bleeding, and severe blood loss. These risks can be serious and possibly fatal. I understand and freely assume these risks. Risks and side effects associated with anesthesia or sedation will be discussed with me before I have my procedure. I may be asked to sign a separate consent regarding anesthesia or sedation prior to my procedure.
3. **ALTERNATIVES**: Reasonable alternative(s) to this procedure have been explained to me by my practitioner. He or she discussed the risks and benefits of not having the procedure. Knowing this information, I choose to have the procedure(s) described on this form.
4. **BENEFITS:** My practitioner has discussed with me the possible benefits associated with this procedure. I understand that there is no certainty that I will achieve these benefits. No guarantee(s) has/have been made to me regarding the outcome of this procedure.
5. **CARE TEAM:** I authorize my practitioner, _____ *[Practitioner's name],* to perform this procedure. I accept that he or she will be assisted by a care team which may include: anesthesia providers, nurses, technicians, medical device specialists, and a surgical team. This team may include other attending surgeons, residents, fellows, medical students or other allied healthcare professionals. I authorize such associates or assistants to perform portions of the operation or procedure under the direction of the physician identified above.
6. **PRESENCE IN OPERATING ROOM:** My practitioner or another appropriately qualified provider designated by my practitioner will be present for the substantial majority of the surgical or invasive procedure including the key and critical portions, and once those portions of the operation or procedure are completed, he/she may leave the operating room. I understand that if the practitioner listed above leaves the operating room where I am having my surgery, he/she or another appropriately qualified provider will be immediately available at all times to assist with or supervise my procedure if necessary.
7. **OBSERVERS:** My practitioner may allow observers during my procedure. They are not part of the care team and will not participate in providing care.
8. **BLOOD TRANSFUSION:** My practitioner and I have discussed the potential for blood transfusion related to this procedure as marked below and my preference regarding transfusion, even when transfusion may be life-saving.
Practitioner: Please check the relevant option below. The selection here is NOT evidence of consent or refusal; it provides direction for the appropriate documentation of those decisions. To proceed with either consent or refusal of transfusion complete relevant separate document.

☐ Blood transfusion is not expected to be necessary for this procedure. No pre-transfusion testing (Type and Screen) is being done. No additional forms are required.

☐ Blood transfusion may become indicated. Pre-transfusion testing (Type and Screen) is expected. To document consent for transfusion use form #397073- *Informed Consent for Blood Transfusion*.**

☐ The patient DOES NOT consent for blood transfusion, even when transfusion may be life-saving. To document refusal of transfusion please follow the applicable *Clinical Standard: Bloodless Program: Adult* or *Bloodless Program: Neonatal, Pediatric, and Adult Dependent*.**

Day of Procedure
**Verify patient's signed documents are in the medical record.
RN/Tech initials _____
Date _____
Time _____

9. **PATHOLOGY:** I accept that any specimens, such as tissue, blood, bodily fluids, etc. will be examined, disposed of or stored for future use in medical studies or research. Any research involving specimens will be reviewed by an appropriate review board. I understand that my tissue or other explanted material will not be returned to me. Requests for exceptions will be reviewed on a case-by-case basis.
10. **VIDEO or PHOTOGRAPHY RECORD:** I understand video or photography records made as part of my treatment and/or diagnosis may be useful for clinical education or professional publications. If used in this way, I understand that my records will be edited so that I will not be identified (referred to as "de-identified"). Video or photography records will not be used for any other purpose without my authorization.

_____ *(Patient's initials)* **I <u>DO NOT</u> authorize my de-identified video or photography records to be used for clinical education or professional publications.**

Any questions I have had regarding this procedure have been answered to my satisfaction. By signing below, I attest to my consent to this procedure.

Signature (Patient or Legal Representative)	Print Name	**DATE**	**TIME**

Relationship (If other than Patient)

Consent Update
Patient consent validation, if patient signature date is greater than 90 days prior to the procedure date.
Practitioner initials _____
Date _____
Time _____

PRACTITIONER'S STATEMENT:
I have explained the contents of this document to the patient/legal representative and have answered all the patient's questions, and to the best of my knowledge, I feel this patient has been adequately informed and has consented.

Practitioner's Signature	Print Name	**DATE**	**TIME**

☐ Yes – Interpreter was used as part of this process.

PATIENT LABEL

SEATTLE, WASHINGTON

CONSENT FOR SURGERY OR OTHER INVASIVE PROCEDURAL TREATMENT