UAB MEDICINE

CONSENT TO: PROCEDURE(S), TREATMENT(S), AND/OR ANESTHESIA

I authorize the following practitioner(s) [Name of practitioner(s) performing procedure]:

_____

to perform the following PROCEDURE/TREATMENT: [Spell out all words, do not abbreviate, and identify side/level of procedure to be performed upon if applicable]:

_____

_____

1. My practitioner has explained and the proposed procedure/treatment to me.
2. No guarantees about any cure or the results of the procedure/treatment have been made.
3. I have been informed of what to expect post procedure/treatment, including, but not limited estimated recovery time, anticipated activity level, additional follow up treatment or therapies, and the possibility of additional procedures/treatments.
4. Alternative methods and therapies (including doing nothing), their benefits, material risks and disadvantages have been explained to me.
5. Procedures or treatments may involve the use of a Food and Drug Administration (FDA) approved drug or device for a purpose not approved by the FDA. I consent to the use of off-label drugs or devices for the proposed procedure or treatment.

RISKS/BENEFITS: Any procedure or treatment may involve the risk of an unsuccessful result or complication, including but not limited to: bleeding, infection, nerve/nervous system damage (including stroke and/or paralysis), injury to organs/structures, blood clots, or even death from both known and unforeseen causes. You have the right to be informed about your proposed care, treatment, services, medications, interventions, operation or procedure, and its material risks, benefits, side effects, potential problems related to recuperation, and the likelihood of achieving your goals.

The material risks and anticipated benefits of the procedure/treatment have been explained to me.

6. I understand that the explanations that I have received are not exhaustive or all-inclusive but are sufficient for me to consent to the proposed procedure/treatment.
7. I understand that in an emergency, or due to unforeseen conditions, there may be different or further procedures, medications, or invasive monitoring necessary to improve my condition. I consent to such procedures and treatments when indicated.

CARE TEAM: UAB is a teaching institution. This means that resident physicians (Residents), physicians in medical/surgical fellowship (Fellows), and students in medical, nursing, and related health care professions such as nurse practitioners and physician assistants receive training here, and may take part in or observe my procedure or perform examinations or invasive procedures for educational and training purposes. Examinations or invasive procedures conducted for educational and training purposes include, but are not limited to, breast, pelvic, prostate, and rectal examinations, as well as others specified under state law. A team of medical professionals, under the leadership, direction, and supervision of my physician/practitioner, will work together to perform my procedure/treatment. Members of the team will participate in the procedure at a level of involvement deemed appropriate by my physician/practitioner based on the level of skill and training of the team member and my medical condition. Trained and/or licensed healthcare staff who are not physicians may do part of my procedure, participate in my treatment, or administer anesthesia as allowed by UAB and law.

Healthcare industry representative(s) may be present during procedures to assist with technical support for any equipment or device(s) used.

8. I understand that in addition to my Practitioner designated above, my Care Team may comprise physicians, trainees, students, vendors and others who may observe or participate in my procedure/treatment.

OVERLAPPING PROCEDURES: (*Applies to procedure areas*) There may be times when the attending physician is overseeing the care provided by teams in two operating/procedure rooms at the same time (defined as "overlapping procedures"). While the attending physician may not be present for the entire procedure, the attending physician will be present during the critical parts of all procedures and the attending physician or another qualified physician will be immediately available should the need arise during the procedure.

9. I understand and consent to overlapping procedures as indicated.

RESEARCH AND EDUCATION: UAB's mission includes research and education. UAB may keep, examine, use, retain, or dispose of anything removed during the procedure ("Specimens"). Specimens and information may be used for research, education, or other activities that support UAB's mission in accordance with applicable law. Specimens include, but are not limited to, any tissue, blood, organs, bones, bodily fluids, or medical devices.

10. UAB may keep, use, or dispose of Specimens. I acknowledge that I do not own the Specimens or any data that might be derived from the Specimens, and have no right to any research or research product using or derived from the Specimens.

ANESTHESIA: I understand that the administration of anesthesia, sedation, and/or associated procedures (collectively referred to as "anesthesia") may be necessary to assure safety and comfort during the proposed procedure/treatment. I understand that certain additional risks and complications may be associated with the use of anesthesia. The appropriate practitioner will discuss these risks with me prior to the procedure. Material risks of anesthesia include, but are not limited to: allergic/adverse reaction, aspiration, brain damage, cardiac complications, coma, dental damage, eye injury, headache, muscle aches, nausea, pain, paralysis, pneumonia, positional nerve injury, recall of sound/noise/speech by others during surgery, and, in rare circumstances, death.

11. I have been advised of the material risks of anesthesia associated with my procedure/treatment and my medical condition. I wish to proceed with and consent to anesthesia if indicated by the anesthesia provider or my practitioner.

BLOOD: I have been informed if blood use is anticipated during my procedure. I also understand that with any procedure, the use of blood and/or blood products may be necessary. My physician/practitioner has explained the risks involved with the administration of blood transfusions or blood products including: transfusion reactions, transmission of disease, and unforeseeable risks including death.

12. **I consent to the use of blood or blood** products during the procedure and subsequent hospitalization if indicated. _____ **(initial only if ACCEPTED)**

13. **I do NOT consent to the use of blood or blood products** even when the use of blood or blood products may be life saving. I understand that if I choose NOT to consent to blood products that I must notify my physician/practitioner immediately and will be asked to sign the Refusal to Permit Blood Transfusion form. _____ **(initial only if DECLINED)**

IMAGES/RECORDINGS: I understand that certain procedures/treatments are routinely recorded, imaged, or

photographed and may be used in the diagnosis and documentation of medical conditions, and/or for clinical education or professional publications. I further understand that my identity will be concealed (de-identified) and my privacy maintained if the material is used for educational or professional purposes.

14. I consent to the taking of pictures, videotapes, or other electronic reproductions of my medical or surgical condition or treatment, and the use of the pictures, videotapes or electronic reproductions, for treatment or internal or external activities consistent with the Hospital's mission, such as education and research, conducted in accordance with Hospital policies.

ADDITIONAL COMMENTS or NOTES: _____

_____

_____

Translation used – This document has been accurately and completely translated, with assistance by an approved translator or approved translation service to the signatory identified above in the patient's/patient representative's preferred language. The patient/patient representative indicated their understanding of all terms and conditions and acknowledged his/her agreement by signing this document.	Preferred Language if not English: Name and Department of Interpreter/Interpretation Service Name and Interpreter's ID #

PATIENT or SURROGATE:

- **I have had the opportunity to ask questions and have received all the information I desire about the proposed procedure or treatment.**
- **I understand that I can refuse the proposed procedure or treatment and that other medical care will not be withheld if I decide to withhold or withdraw my consent.**
- **By my signature below, I confirm that I have read and understand the information provided on this form and consent to the procedure or treatment.**

_____ _____ _____
Patient's Signature **Date** **Time**

IF THE PATIENT IS A MINOR or UNABLE TO SIGN, COMPLETE THE FOLLOWING:
Surrogate's Name (Print): _____
Address: _____
Relationship: _____
Patient cannot sign because: _____

_____ _____ _____
Surrogate's Signature **Date** **Time**

WITNESS ATTESTATION: I witnessed the patient/surrogate signature(s) above.

_____ _____ _____
Witness's Signature **Date** **Time**

PROVIDER INFORMED CONSENT ATTESTATION:
I have discussed the procedure or treatment described above with the patient or surrogate.

_____ _____ _____
Provider's Signature **Date** **Time**