

Consent To Surgery Or Special Procedures

Identification Plate

I. Dr. _____ has told me that I have the following condition:

Need for intravenous access and vascular monitoring

Due to this condition, the doctor has recommended the following operation or treatment:

Insertion of central line

to be performed by Dr. _____ and/or the associates or assistants.

The doctor has explained to me that:

1. This operation or treatment generally consists of the following:

Puncture vein with a needle, insert wire, and place catheter, suture catheter in place

2. The benefits and likelihood of success of the operation or treatment are as follows:

Provide a more secure access to the vein to give medications, TPN or to draw blood samples.

Don't have to start a new IV each time medications are given, or blood samples are needed.

Allows administration of medications that cannot be given by peripheral IV's.

3. The following risks are involved in this operation or treatment:

Bleeding; pneumothorax (collapse of the lung); hemothorax (blood around the lung);

irregular heart beat; injury to other organs or structures; injury to nerves.

Need for chest tube placement or further surgery

4. The following are potential problems related to the recuperation from this operation:

Pain; infection; problems with wound healing.

Clot formation in the vein around the catheter. Swelling of the arm or neck.

Catheter could clot off, become dislodged, break off, get pulled out, or not work properly.

The listed risks and potential problems related to recuperation are the most common complications of this operation or treatment. They do not include all conceivable consequences of the procedure.

5. My condition could also be treated in the following ways:

Use peripheral IV's (in the arms, legs, or head).

The benefits and risks involved in the alternative operations or procedures are:

No surgery.

Need for repeated IV's; loss or scarring of the veins; risk of infiltration of medications.

Cannot receive medications that need to be given through a central vein.

6. There is no guarantee that this operation or procedure will improve my condition.

7. If I am not operated on or treated as the doctor recommends, the following may happen to me:

Could slow the treatment or therapy.

Cannot receive medications that need to be given through a central vein.

This form cannot be altered in any way without first contacting the hospital's risk manager

- II. 1. Surgery and anesthesia involve risks such as severe loss of blood, infection, and heart stoppage.
2. The doctor has also explained to me that sometimes during surgery, it is discovered that additional surgery is needed. If, in the opinion of the doctor who is operating, I need such additional surgery, I permit the doctor to proceed.
3. I understand that I will be undergoing an operation. One of the risks of having surgery is blood loss. My surgeon has explained to me that a blood transfusion (injection of blood into a vein) may be required to treat blood loss. Transfusions may be necessary so that different organs (body parts like the heart, liver, and kidney) will receive an amount of oxygen that is necessary to maintain proper function. I also understand that I may require treatment with blood components that helps my blood to clot properly.

The risks, benefits, and alternatives to transfusion have been explained to me. I also understand the possible consequences of refusal of blood transfusion. I understand that my benefits of receiving a blood transfusion are not guaranteed. All of my questions have been answered to my satisfaction. I am fully aware of the risks of refusing the transfusion of blood or blood products, and agree to hold West Virginia University Hospitals, its staff, employees, and physicians harmless should I refuse.

4. ☐ I **consent** to transfusion of all blood/blood products.
☐ I **consent** to transfusion with certain exceptions (patient designates)

☐ I **refuse** all transfusion of blood/blood products.

"NO BLOOD" sticker placed on front of chart and on patient ID band by:

5. I **consent** _____ I **do not consent** _____ Date _____ Time _____ to be photographed or filmed during the course of my treatment or operation.
6. I authorize the physician(s) and WVUH to preserve for scientific research, or teaching purposes, or to dispose of any tissues, body parts, or organs removed as a necessary part of my care according to hospital policy, with the following exceptions:

None

The information above was given to me and I have had the opportunity to ask questions. All my questions have been answered. Finally, I request that the operation or procedure be performed.	I have received and read (or it has been read to me) an information sheet that explains what blood transfusions are and why they may be necessary.
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X			
(Patient's Signature*)	(Witness)	(Date)	(Time)

*The patient is unable to consent because: _____
I therefore consent for the patient.

(Signature)	(Witness)	(Date)	(Time)

I declare that I have personally explained the above information to the patient or the patient's authorized representative.

X			
(Doctor's Signature)	(Witness)	(Date)	(Time)

Consent by telephone obtained from _____

(Witness who has listened to consent over the telephone)	(Date)	(Time)	

(Witness who has listened to consent over the telephone)	(Date)	(Time)	

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