REQUEST AND INFORMED CONSENT FOR SURGICAL PROCEDURE, SEDATION, ANESTHESIA, AMNIOCENTESIS, OR CONTRAST INJECTION

(For use of this form see MEDDAC Reg 40-28)

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS.

PATIENT'S NAME: _____

The following has been explained to me in general terms and I understand that:

1) The diagnosis requiring this procedure is: *(diagnosis described in lay terms)*

VISUALIZE THE VASCULAR OR URINARY SYSTEM.

2) The nature of the procedure is: *(describe procedure in lay terms)*

INSERTION OF AN INTRAVENOUS CATHETER/NEEDLE FOR THE INJECTION OF INTRAVASCULAR CONTRAST MATERIAL.

3) The purpose of this procedure is: *(specific for this patient)*

TO VISUALIZE VESSELS AND/OR OPACIFIED ORGANS IN TEH AREA TO BE EXAMINED.

4) MATERIAL RISKS OF PROCEDURE: As a result of this procedure being performed there MAY be material risks of: INFECTION, ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC ARREST OR DEATH.

5) In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to:

TECHNICAL INABILITY TO PERFORM PROCEDURE, LOCAL DISCOMFORT, SITE INFECTION, REACTION TO LOCAL ANESTHETIC, DAMAGE TO ADJACENT ORGANS WHICH MAY/MAY NOT REQUIRE SURGICAL INTERVENTION.

6) The likelihood of a successful outcome for the stated procedure is:

☐ Excellent ☐ Good ☐ Fair

7) The generally recognized and accepted practical alternatives to this procedure and the accompanying risks are:

MAGNETIC RESONANCE IMAGING OR ROUTINE FILM FOLLOW-UP.

8) If I choose not to have the above procedure, my prognosis (future medical condition) is:

BASED ON PATIENT'S UNDERLYING MEDICAL CONDITION.

(continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

I understand that the physician(s) and other medical personnel involved in the treatment have relied on statements from the patient, the patient's medical history, and other information in recommending this procedure or course of treatment.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES HAVE BEEN MADE TO ME concerning the results of this procedure nor guarantees to the effect this procedure will have on the underlying disease process.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedure(s) which were unforeseen or not known to be needed at the time this consent is given. I consent to and I authorize the persons described herein to make the decisions concerning performing of such procedures.

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedures described herein.

I also consent that any tissues, specimens, organs, or limbs removed from the patient's body in the course of any procedure may be tested, disposed of or retained for physician, facility or other health care provider.

I understand that photographs and video recordings may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, provided the name of the patient and his/her family is not used to identify said pictures, and that said pictures will be used only for purposes of medical/dental study or research. I understand that my consent is not required if the taping is for the documentation of suspected neglect or abuse.

I acknowledge that I selected Winn Army Community Hospital as my treatment facility and I hereby voluntarily request and consent to the performance of the procedure described or referred to herein by the staff of Winn Army Community Hospital together with any other physician(s) or non-physician(s) designated or selected by it. I consent to the presence of individuals whom the provider feels may gain educational benefit from observing the procedure. I also consent to the presence of sales representatives, when requested by the provider, as they may provide technical advice on supplies and equipment.

By signing this form, I acknowledge that I have read or had this form read and/or explained to me, that I fully understand its contents, that I have been given ample opportunity to ask questions and that any questions

Signature of Counseling Physician/Credentialed Provider	*Signature of Patient*
Date	*Signature of Person Giving Consent (Other than Patient), Relationship to Patient*