South Shore Health
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Patient Identification

INFORMED CONSENT FOR SURGICAL HYSTERECTOMY

PROCEDURE NAME:

CONDITION: I have explained to the patient the nature of his/life condition, the nature of the procedure, and the benefits to be reasonably expected compared with alternative approaches.

RISKS, BENEFITS & ALTERNATIVES:
I have discussed the likelihood of the major risk or complications of the procedure including (if applicable) but not limited to infection, possible injury to adjacent organs (bladder, intestines), ureter damage, hemorrhage (bleeding), drug/anesthesia reactions, blood clots, vaginal problems (future prolapse), future ovary failure, early menopause, adhesions, emotional trauma, loss of sensation, loss of limb function, paralysis, brain damage and loss of life.

I have also indicated that with any procedure, there is always, the possibility of an unexpected complication, and no guarantees or promises can be made concerning the results of any procedure or treatment. This discussion also included
risks of: _____

If I will be administering sedation, the benefits as well as the potential risks, complications and side effects have been discussed.

I have explained to the patient the potential presence of one or more healthcare industry professionals (technical representatives for medical equipment and device companies), during this procedure for advisory purposes only. Such advisors, if any, agree to maintain the confidentiality of patient medical information to the extent provided by the law and in accordance with hospital policy.

CONSENT:
CONSENT FOR THE USE OF BLOOD PRODUCTS: I have discussed the possible need for blood products during the procedure and indicated that the benefits from receiving blood products far exceed the associated risk. I have indicated that unless the patient has pre-deposited his/her own blood, there are no therapeutic alternatives for blood products donated by others. The likelihood of adverse effects, including but not limited to infection, transfusion reactions (fevers, chills, allergic, reaction, fainting, dizziness, bloody urine, kidney failure, nausea, vomiting, diarrhea, chest and back pain) and disease transmission (e.g. Hepatitis C Virus, HIV, and Human T Lymphotropic Virus 1/11, Hepatitis 8, Malaria and bacterial transmission), has been minimized by extensively screening and testing donor products and selecting compatible blood productions for transfusion. Finally, I have explained to the patient that while he/she can choose not to have a transfusion, such a choice may increase the risk associated with bleeding or decrease lung or heart function.

- Consent for Inpatient Transfusion is valid for the hospitalization only.
- Consent for Outpatient Transfusion is valid only for a single chronic condition, for a period not to exceed one year.

ACKNOWLEDGEMENT:
____ YES, Patient Consents to Blood Products Use ____ NO, Patient Does Not Consent to Blood Product Use
____ Consent for blood products not discussed; very unlikely to require blood product transfusion
Additional comments (if any):
_____

All questions were answered and the patient consents to the procedure.

_____	_____	_____	_____
Signature of Physician/LIP	Printed Name of Physician/LIP	Date	Time

The above physician has explained all the above information to me. I understand this information and consent to this procedure

_____	_____	_____
Signature of Patient/Legal Representative	Date	Time
_____	_____	_____
Signature of Witness	Date	Time Witness

Witness Signature is required if a patient's signature is not witnessed by MD/LIP or if consented was obtained over the phone.
IF SIGNATURE CANNOT BE OBTAINED, INDICATE REASON IN COMMENT SECTION ABOVE.