Authorization for Laparoscopic Hysterectomy

Patient’s Name: ___________________________________

I hereby authorize Dr._____________________________ to perform the following surgery:

Laparoscopic Hysterectomy.

I understand that residents, medical students, physician assistants and/or advanced practice registered nurses may also be in attendance, and/or assisting in the performance, and/or performing significant medical/surgical tasks within the above specified surgery. In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above listed surgery that require the assistance of other qualified medical personnel who have not been identified.

I have had explained to me in connection with the proposed surgery: (i) the nature and purpose of the proposed surgery; (ii) the foreseeable risks and consequences of the proposed surgery, including the risk that the proposed surgery may not achieve the desired objective; (iii), the alternatives to the proposed surgery and the associated risks and benefits to such alternatives; and (iv) the reasonably foreseeable risks and alternatives to the transfusion of blood and blood products should I need a blood transfusion.

Specifically, in obtaining my informed consent to the surgery, I have been informed of the following reasonably foreseeable risks:

- Bleeding requiring transfusions
- Injury to nerves
- Infection
- Possible need for abdominal incision
- Injury to bowels
- Blood clots in lungs or legs
- Injury to a major blood vessel
- Injury to bladder
- Injury to ureters

___________________________ ___________________________ __________________________

________________________

Patient initial

I am aware that, in addition to the reasonably foreseeable risks described, there are other foreseeable risks, which have been discussed with me, but are not listed. I affirm that I understand the purpose and potential benefits of the proposed surgery, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed surgery.

If power morcellation is considered the best therapeutic option for me, my physician has explained that my fibroid may contain unexpected cancerous tissue and that the laparoscopic power morcellator may spread the cancer, significantly worsening my prognosis. I also understand that my surgeon will use a specimen bag during morcellation in an attempt to contain the uterine tissue and minimize the risk of spread into the abdomen and uterus

___________Patient initial
I agree to the use of anesthesia and/or sedation/analgesia as required, and if applicable, the disposal of any tissue removed.

I also authorize the Hospital and the above-named physician(s) to photograph, video and/or use any other mediums which result in the permanent documentation of my image for medical, scientific or educational purposes, provided my identity is not revealed by them. I agree that any photographs taken pursuant to this authorization, which are not required by law to be retained, may be disposed of by the Hospital so long as the manner of disposition shall be permanent destruction.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

_________________________  ____________________________
Signed: ___________________  ____________________________
  (Patient or legally authorized representative)

Date: ______________  Time: ______________  Date: ______________  Time: ______________

Interpreter responsible for explaining procedures and special treatment:

_________________________________________________  (Interpreter)

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [ ] BECAUSE:

_________________________________________________  M.D.  Date: ______________  Time: ______________

_________________________________________________  Witness  Date: ______________  Time: ______________