



Authorization for Bronchoscopy (with or without biopsy) in the Intensive Care Unit

Please read this document carefully and in its entirety. Signing this document means that you have read the entire document and understand the contents herein and the potential risks of the bronchoscopy for which you are consenting while in the Hartford Hospital Intensive Care Unit.

I understand and acknowledge that certain treatments and procedures are standard for patients receiving care in the Hartford Hospital Intensive Care Unit (the "ICU") and may be necessary for diagnostic or therapeutic purposes while I am a patient in the ICU. I also understand and acknowledge that my illness, the anesthesia, sedatives and analgesics used to diagnose or treat my illness and the need to act without undue delay may make it difficult to obtain informed consent on each occasion prior to the performance of a diagnostic or therapeutic treatment or procedure.

I understand that I may not need a bronchoscopy, but to the extent that I do, I am consenting in advance. Should I need a bronchoscopy and I am capable of giving consent, the clinical staff will inform me once again of my choices.

In anticipation that a bronchoscopy may be necessary for diagnostic or therapeutic purposes while I am a patient in the ICU, I hereby authorize my attending physician or the physician on duty to perform the procedure. I also authorize other Hartford Hospital staff to assist for the purpose of performing medical or surgical tasks as part of the procedure.

I understand that interns, residents, and/or medical students may also be in attendance and/or assisting in the performance of the bronchoscopy. In addition, I understand that there may be emergency and/or unforeseen circumstances that are encountered while performing the procedure that may require the performance of additional procedures.

I have had explained to me: (i) the nature and purpose of the proposed and potentially necessary treatment and procedure; (ii) the foreseeable risks and consequences of the proposed and potentially necessary treatment and procedure, including the risk that the proposed and potentially necessary treatment or procedure may not achieve the desired objective; and (iii) the alternatives, if any, to the proposed and potentially necessary treatment and procedure and the associated risks and benefits to such alternatives, including the risks and benefits of not undergoing the treatment and procedure. Specifically, in obtaining my informed consent to the proposed and potentially necessary treatment and procedure, I have been informed of the following purposes and benefits, reasonably foreseeable risks and alternative therapies associated with the treatment and procedure listed below:



Bronchoscopy (with or without biopsy):

- a. Nature and purpose of treatment/procedure: A small fiberoptic tube is placed into your bronchial tubes to allow visualization of the lining and airways of the lung, remove excessive secretions, assist in the diagnosis of pneumonia and visualize other problems within the lungs. It may also be used to guide placement of a tracheostomy tube or biopsy a suspicious area that may be identified on the lining of the breathing tubes.
- b. Material risks of treatment/procedure: Risks may include bleeding, infection, collapse of the lung, breathing difficulty, abnormal heart beats, medication reactions, discomfort, and death.
- c. Alternative therapies: There are no equally effective alternative therapies.

I am also aware that, in addition to the reasonably foreseeable risks described above, that there are other foreseeable risks which have been discussed with me, but are not listed above. I affirm that I understand the purpose and potential benefits of the proposed and potentially necessary treatment and procedure, 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 and potentially necessary treatment and procedure.

I agree to the use of sedation/analgesia as required in connection with the above procedure.

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

SIGNATURES ON THE FOLLOWING PAGE



6816



Physician/PA/APRN

Date

Time

Patient Signature

Date

Time

Legally Authorized Representative Signature

Date

Time

Interpreter responsible for explaining procedures and special treatment:

Interpreter

Date

Time

PATIENT UNABLE TO SIGN PRIOR TO TREATMENT OR PROCEDURE BECAUSE

Witness: _____ M.D.

Date

Time

Signed: _____

Witness: _____

Date

Time

Signed: _____