Hartford Hospital
A Hartford HealthCare Partner

6816

Authorization for a Surgical Tracheostomy

Patient's Name: _____

I hereby authorize Dr:_____ to perform the following surgical procedure(s):

- ☐ **Open Tracheostomy**
- ☐ **Percutaneous Tracheostomy**
- ☐ **Bronchoscopy**

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

I have had explained to me in connection with the proposed surgery/procedure: (i) the nature and the purpose of the proposed surgery/procedure; (ii) the foreseeable risks and consequences of the proposed surgery/procedure, including the risk that the proposed surgery/procedure may not achieve the desired objective; (iii) the alternatives to the proposed surgery/procedure 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.

Surgical risks and potential complications include

- Bleeding
- Tracheo-Innominate Fistula / Large Vessel Injury
- Infection / Abscess
- Loss of Airway
- Pneumothorax
- Hypoxia
- Disfiguring scar
- Anoxic Brain Injury
- Airway Scarring / Subglottic Stenosis
- Airway injury/fracture
- Tracheomalacia
- Esophageal Perforation
- Failure of the Procedure
- Abnormal heartbeat
- Conversion from percutaneous to open tracheostomy
- Conversion from bedside procedure to operating room procedure
- Fire
- Death
- Other: _____

Hartford Hospital
A Hartford HealthCare Partner

6816

Authorization for a Surgical Tracheostomy

I am aware that, in addition to the reasonable 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/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 surgery/procedure.

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 maybe revocable by me at any time, except to the extent it has already been relied upon.

_____ Signed: _____

MD, APRN, PA (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:_____