Consent Forms

**Saint Luke's Hospital**
**Kansas City, MO 64111**

# CONSENT TO OPERATION, TREATMENT, TRANSFUSION OR OTHER PROCEDURES

PATIENT: _____ DATE OF BIRTH: _____

1. I hereby authorize Dr. _____ and whomever he/she may designate as his/her assistants, to perform in Saint Luke's Hospital of Kansas City, Missouri, the following procedures:

_____
(identify specific site - no abbreviations)

_____

and if any unforeseen condition arises or becomes apparent in the course of the procedure that, in his/her judgment, calls for procedures in addition to or different from those now contemplated, I further request and authorize them to do whatever they deem advisable.

2. The nature, purpose, benefits, risks, and possible alternative options to the procedure, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

3. a. I consent to the administration of anesthesia by or under the direction of WESTPORT ANESTHESIA or CARDIOTHORACIC ANESTHESIA ASSOCIATES and to the use of such anesthetics as he/she may deem advisable, with the exception of

_____
(write none or specific exception)

b. I consent to the administration of sedation by or under the direction of my physician and to the use of such medications as he/she may deem advisable, with the exception of

_____
(write none or specific exception)

4. I am aware that sterility may result from this procedure although such results have not been guaranteed. I know that a sterile person cannot conceive or fertilize a pregnancy. (Strike through if statement not correct for identified procedure.)

5. I understand that the transfusion of blood and/or blood products may be required for me during the course of the above named procedure and I voluntarily consent and authorize transfusion. I understand that no warranty or guarantee has been made to me as to result or cure. I also realize that the following risks and hazards may occur in connection with blood transfusion, including but not limited to: fever, transfusion reaction which may include kidney failure or anemia, heart failure, hepatitis, A.I.D.S. (acquired immune deficiency syndrome), and other infections.

**Affix Patient Label To ALL Pages**

***Continued on Page 2***

**Initials** _____ **Date** _____

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6. I hereby authorize Saint Luke's of Kansas City, Missouri to preserve for scientific or teaching purposes, or for use in grafts upon living persons, or otherwise dispose of the dismembered tissue, parts or organs resulting from the procedure authorized above.

7. I hereby authorize the release of my Social Security number to the manufacturer of the medical device that I am to receive in accordance with Federal Food and Cosmetic Act Section 519(e). I further understand that my Social Security Number may be used by the manufacturer to locate me if there is a need to contact me in regard to this medical device.

8. I hereby consent to the taking of pictures, television recordings or videotape recordings of medical or surgical conditions or procedures and for use of such pictures or films for educational purposes, without expense to me.

9. I consent to the above radiological procedure. I understand that I am pregnant or could be pregnant and in that regard have been informed of the risks, including potential adverse effects to me and/or my embryo fetus, and benefits associated with this x-ray procedure during pregnancy.

10. In the event that a health care worker is exposed to my blood, I consent to the drawing of my blood for testing for HIV or hepatitis infection.

I CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I HAVE READ IT OR HAVE HAD IT READ TO ME, AND THAT I UNDERSTAND ITS CONTENT. ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION ARE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, ARE STRICKEN.

| | |
|---|---|
| DATE:_____TIME:_____ A.M. P.M. | *Where patient is incapable of signing and another person signs in his stead, fill in the following information:* |
| _____<br>Signature of witness | State why patient is not able to give consent personally (nor to sign this form).<br>Explain: ☐ Minor ☐ Unconscious ☐ Other |
| _____<br>Signature of witness<br>*(phone permission requires two witnesses)* | _____<br>Patient/Other legally responsible signature |
| *Saint Luke's Hospital*<br>Address of witness(es) | _____<br>Relation of signer to patient |

Prior to the time of the procedure/transfusion above described, I explained to the patient named above and to any person who has consented to the procedure on the patient's behalf, the nature, purpose, benefits, and risks of the procedure as stated as well as possible alternative options. I have further discussed possible consequences of the procedure, the principal risks involved, and possible complications.

**Affix Patient Label To ALL Pages**

_____, M.D. _____ DATE