Valley Surgery Center

Informed Consent Information

Informed Consent for Surgery, Medical, or Diagnostic Procedures

This area will describe the surgery ordered.

1. **I have talked to my doctor about:**
   - What the procedure is and what will happen.
   - How it may help me (the benefits).
   - How it might harm me (the most likely and most serious risks).
   - The long-term effects of the procedure.
   - My other choices for treatment. The risks and benefits of those choices.
   - What will happen if I say “no” to this procedure.
   - How I might feel right after the procedure, and how quickly I can expect to recover.
   - What medicines will be used to manage pain or sedate me.

2. **I agree that:** *(If I do not agree with a statement, I have told the witness who has indicated my desires below under "instructions and special needs.")*
   - I will ask questions.
   - No one has promised me definite results and no guarantee has been made regarding specific visual outcomes.
   - If it is best for me, my doctor may change the plan during the procedure. I permit the surgeon to use his/her best judgment to do whatever is most appropriate for my care.
   - Students and others may watch the procedure. This must be approved by this facility.
   - Pictures or videos may be taken. They may be used for medical or educational purposes only.
   - Tissues or items removed from my body may be tested. They will be disposed of with respect. Unless I agree, tissues will not be used for research or sold.
   - If a staff person is exposed to my blood or body fluids, my blood will be drawn by Hudson Physicians, located in the same building as the Valley Surgery Center, and tested for HIV and hepatitis. The test results will go to me, my medical record, the exposed worker, the facility's employee health service department, and to Wisconsin health officials.

3. **I understand that:**
   - Medicine and surgery are not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the surgery.
   - The surgeon has discussed the risks of the planned surgery and answered all of my questions.
   - I can change my mind. If I do, I must tell my doctor or team as soon as possible.
   - The administration of medication and anesthesia drugs involves risks, including the risk of brain damage or death.
   - I have been advised to have someone with me until the morning after surgery if I receive sedation during my procedure.
   - The team will verify who I am and what procedure I am having performed in the preoperative area, the operating room, and any other procedure room.

Anesthesia:

For patients having procedures with anesthesia: It has been explained to me that all forms of anesthesia involve some risks and no guarantees can be made concerning the results of my procedure(s): Although rare, unexpected complications with anesthesia can occur and include but are not limited to: airway trauma including but not limited to bruised lip or broken teeth, aspiration of stomach contents into the lungs, eye irritation, infection, bleeding, drug reactions, allergic reactions, blood clots, loss of sensation, loss of limb function,

paralysis, stroke, brain damage, heart attack and death.

I understand that the type of anesthesia provided and the technique to be used is determined by many factors including my physical condition, the type of procedure my physician is to perform, my doctor's preference and my own preference. It has been explained to me by an anesthesia provider that sometimes anticipated anesthesia techniques may not succeed completely and therefore another technique may have to be used including general anesthesia. I will have the opportunity, prior to my procedure to speak with my anesthesia provider if I have further questions.

I understand that it may be necessary to be placed under anesthesia to perform the operation described to me by my physician/surgeon, and I consent to the use of anesthesia and the level of anesthesia as deemed necessary and appropriate by my anesthesia provider. This may include monitored anesthesia care, regional anesthesia, and/or general anesthesia. Anesthesia involves risks in addition to the risk of the surgical procedure itself. These risks include but are not limited to, adverse drug reactions, damage to teeth or dental work, eye irritation, damage to vocal cords, nerve injury, brain damage, heart attack, death, aspiration of stomach contents into the lungs, pain and discomfort, damage to arteries or veins, or worsening preexisting diseases. The purpose, necessity, and risk of anesthesia has been explained to my satisfaction and there has been sufficient opportunity to discuss the proposed treatment and associated risks. I also authorize the release of medical information necessary to process the anesthesia claim.

I declare and represent that I have read the above and understand it to be true. No guarantee or warranty has been made to the results the anesthetic procedures.

I certify that I have informed the patient or his/her representative of the nature and type of anesthesia, choices whenever possible, risks and potential complications.

Surgery During a Global Pandemic

I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I am aware that COVID-19 is extremely contagious, spread by person-to-person contact, and that state and federal health agencies recommend social distancing. I recognize that the staff at the Valley Surgery Center are closely monitoring the situation and have implemented preventative measures to reduce the spread of COVID-19. Nonetheless, I acknowledge and assume the risk of becoming infected with COVID-19 before, during, or after the procedure. I understand the potential for short-term and long-term risks related to COVID-19, including the need for quarantine/ self-isolation, medical testing, hospitalization, respiratory or other organ system complications, and death. I have been given the option to defer my procedure to a later date and would like to proceed as scheduled.

Patient Signature:_____ Date:_____
(or person authorized to sign for patient)

Witness/Physician Signature:_____ Date:_____