I. Information provided:

I,_____,(Name of Patient or Designated Decision Maker) have been informed that the surgery, procedure, or treatment to be performed is to: (site) Knee Arthroscopy (side), the purpose of which is improve knee stability.

II. **Documentation of Informed Consent**

X On Form __Attached Office Note __Progress Notes __H&P

1. I understand that the **potential benefits and outcomes** of the proposed surgery, procedure, or treatment include but are not limited to: Improve knee stability
2. I understand that the **potential risks and complications** associated with the surgery, procedure, or treatment include but are not limited to: bleeding/ infection/ blood clot, injury to nerve/vessal/tendon graft failure, graft infection, graft rejection, failure of surgery, need for further surgery.
3. **Alternatives** to the proposed surgeries, procedures, and treatments for my condition including the option of no treatment have been discussed with me. These include but are not limited to:no surgery.

III. **Serial Procedures –** I understand that I will receive a series of the same treatments over a time period not to exceed 180 days.

From ___/___/___to___/___/___ N.A._____

IV. **Specific to Surgery**

1. It has been explained to me that sometimes during surgery, it is discovered that additional surgery is needed. If, in the opinion of the doctor who is operating, I need such additional surgery, I permit the doctor to proceed.
2. I consent to being photographer or filmed during the course of m operation or treatment. I understand that and that the photographs/films will be used for educational and research purposes only and that my name will not be placed on the photographs/films used for educational and research purposes. I understand the photographs intended for my medical record will be identified by my name and may not be released or used without my expressed agreement. **NA _____**I do not want my photographs/films released or used for educational purposes.
3. I authorize the physicians and the INOVA Health System to preserve for scientific research, or teaching purposes, or to dispose of any tissues, body parts, or organs removed as a necessary part of my care according to hospital policy, with the following exceptions: _____ (send copy of any exceptions to Department of Pathology.
4. I understand that, at the request of my physician, a vendor or medical equipment representative may be present during the performance of my procedure. Presence shall be limited to providing information for coordination of treatment and technical expertise on the use and operation of the vendor's device under the supervision of my physician. **NA_____**

2. I consent to being photographed or filmed during the course of my operation or treatment. I understand that photographs/films will be used for educational and research purposes only and that my name will not be placed on photographs/films used for educational and research purposes. I understand the photographs intended for my medical record will be identified by my name and may not be released or used without my express agreement.
❑ I do not want my photograph/films released or used for educational and research purposes. ❑ NA

3. I authorize the physicians and the Inova Health System to preserve for scientific research, or teaching purposes, or to dispose of any tissues, body parts, or organs removed as a necessary part of my care according to hospital policy, with the following exceptions: _____
(Send copy of any exceptions to Department of Pathology)

4. I understand that, at the request of my physician, a vendor or medical equipment representative may be present during the performance of my procedure. Presence shall be limited to providing information for coordination of treatment and technical expertise on the use and operation of the vendor's device under the supervision of my physician. ❑ NA

5. I understand that other practitioners such as surgical residents, surgical first assistants, RN first assistants, and physician assistants may assist my surgeon in performing important parts of my surgery, and that the type of assistance these practitioners will provide, if any, may not be known until the procedure begins. Each practitioner will have appropriate skill sets to participate in the procedure and will be under the supervision of the primary surgeon. I understand the names of other practitioners and the tasks they performed will be documented in the medical record.

VI. Consent – Consent expires within 30 days of signatures except for serial procedures with documented dates. I have had the opportunity to ask questions and have them answered.
I understand the risks, benefits, and alternatives associated with the proposed operation, procedure, or treatment. I consent to the operation, procedure, or treatment to be performed. **Yes** _____ **No** _____

_____
Patient's Signature Date Time

_____
Witness Signature Date Time

The patient is unable to consent because: _____
Therefore I consent for the patient.

_____
Designated Decision Maker Date Time

Relationship: _____

I declare that I have personally explained the above information to the patient or the patient's designated decision maker.

_____
Physician/Practitioner Date Time

Consent by telephone obtained from:

_____
Witness who has listened over the telephone Date Time
Licensed Clinician

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM
INFORMED CONSENT FORM
SURGICAL PATIENTS

CAT #96066A / R012511 • PKGS OF 50