Informed Consent Form

Surgery with Blood Consent

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***: Hip Resurfacing arthroplasty***(site)_____(side)_____, the purpose of which is to hip arthritis.

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: ***return to active lifestyle***
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/ tendon, fracture, dislocation, foot drop, leg length discrepancy, failure of surgery, loss of limb or life, failure of hardware
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_____**

VI. Consent – Consent expires within 30 days of signatures

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.

Surgery **Yes** _____ **No** _____
Blood **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 Signature	Date	Time

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

Physician	Date	Time

Consent by telephone obtained from:

_____

Witness who has listened over the telephone Licensed Clinician	Date	Time

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.

V. **Transfusion of Blood Products** (Red Blood Cells, Platelets, Fresh Frozen Plasma and Cryoprecipitate)

Benefits of Blood Product Transfusion-

Symptoms that may improve after a transfusion include:

- anemia
- bleeding problems
- acute blood loss

Risks

- I understand that blood transfusion(s) may be required during my surgery or procedure
- All blood products have a minimal risk of transmitting an infectious disease and are tested according to federal guidelines. However, no screening process is 100 percent effective and some risks will remain. Viruses are not commonly transmitted but could cause a serous disease.
- Using our current testing methods the risk of getting HIV is less than one in 1.9 million units, Hepatitis C is less than one in 1.8 million units and Hepatitis B is less than one in 205,000 units.
- Other risks include bacterial contamination of blood (which may result in life threatening infection) and transfusion errors, which are rare.
- Multiple organ dysfunction and death
- Transfusion reactions which are unpredictable could include:
    - fever and chills
    - allergic reactions which may cause itching and hives and could become serious
    - shortness of breath and/or destruction of the transfused red blood cells, affecting the kidneys or liver and possibly causing jaundice
    - chest pain
    - pounding headache and /or flushed feeling
    - a delayed reaction 10 to 14 days after the transfusion which can shorten the effective life of the red blood cells.

Please notify your nurse or physician if you experience any of these symptoms.

Alternatives to Blood Product Transfusion

Please be sure to discuss the alternatives with your physician. Make sure you understand what will happen if you chose not to have a blood transfusion

_____

_____

I have reviewed and understand this information on blood transfusion and have had the opportunity to ask questions of the physician and understand the risks, benefits and alternatives involved in transfusion therapy.

❑ **BLOOD ADMINISTRATION IS NOT ANTICIPATED FOR THIS PROCEDURE**

_____ I consent to the transfusion of all blood products

_____ I consent to the transfusion of all blood products with certain exceptions (patient designates):

_____

_____ I refuse to give consent for transfusion of all blood products