5-Hole 1/4 1 3/8 c-to-c

☐ **Bethesda Butler Hospital**
☐ **Bethesda Surgery Center**
☐ **Bethesda North Hospital**
☐ **Good Samaritan Hospital**
☐ **TriHealth Endoscopy Center North**
☐ **TriHealth Evendale Hospital**
☐ **TriHealth Hand Surgery Center**
☐ **TriHealth Surgery Center/West**
☐ **McCullough-Hyde Memorial Hospital**
☐ **Other:** _____

I, _____, (Date of Birth) _____), and my practitioner,_____,
have talked about my condition. My practitioner has recommended _____

_____

_____ to treat my condition.

My practitioner and I have talked about, and I understand the following:

- The potential benefits of this care, what might happen if I do not treat my condition, the alternative ways to treat my condition, the material risks and benefits of the proposed care and the alternatives, the likelihood of achieving my goals by receiving the care, and the potential problems that might occur during my recovery after receiving the care
- There can be risks or side-effects whenever someone receives care. I know my practitioner cannot tell me about every possible risk or side-effect. We did talk about the common ones (for example: **bleeding, infection, pneumonia, heart issues, blood clots, possible damage/injury to surrounding tissue, and death**) that could happen if I receive the care. Additional possible risks of this care include, but are not limited to: _____

  _____
- I consent for my practitioner(s) to do any other care other than the care listed above that may be necessary while providing the care listed above.
- No guarantees have been given to me about the results of the care or any cure. My condition may not get better, or may even become worse as a result of the care.

I understand that the hospital is a teaching facility and that assistants, residents, trainees and others may participate in my care based on their skill set and scope of practice and as permitted under state law and for which they have been granted privileges by the hospital. These individuals will be under the supervision of my practitioner(s). I agree to allow the hospital to throw away or use for scientific or educational purposes any tissue or body parts that are taken out during my care.

I understand that if I need sedation or anesthesia for the care, sedation will often result in short term loss of memory and coordination. Sedation may lead to general anesthesia. I understand that the material risks of anesthesia include but are not limited to: **sore throat, hoarseness, injury to face, mouth, teeth, or eyes, nausea, headache, injury to blood vessels or nerves, brain damage, paralysis, or death**. I agree to allow the administration of sedation and/or anesthesia for the care.

I allow my practitioner(s) to give me blood or blood products. I understand that there is a chance of infection or side effects, and no guarantees have been given by the hospital, any blood bank, person or entity as to the safety of the blood or blood products. The material risks, benefits, alternatives, and side effects of either receiving or refusing to receive blood and/or blood products, as well as the alternatives, have been explained to me.

I have read this form or had it read to me, fully understand the material risks, benefits and alternatives, and had all of my questions answered to my satisfaction, and consent to the above care.

_____	_____	_____	_____AM/PM
Patient/Legal Representative Signature	**Relationship of Legal Representative (if applicable)**	**Date**	**Time**
_____	_____	_____	_____AM/PM
Witness Signature	**Witness Name**	**Date**	**Time**

I have explained to the patient: the purpose of the above care and any reasonable alternatives, the anticipated benefits, the material risks, the likelihood of the patient achieving his/her goals, the potential problems that might occur during recovery, and the reasonably likely result of not receiving the care.

_____	_____	_____AM/PM
Practitioner Signature	**Date**	**Time**

TRM

1185-2 5/16

TriHealth

INFORMED CONSENT TO PERFORM SURGERY OR PROCEDURE

PATIENT IDENTIFICATION LABEL