UPMC LIFE CHANGING MEDICINE *HAMOT*

Consent for Treatment of Breast Disease

IMPRINT PATIENT IDENTIFICATION HERE

Patient Name:____

Planned Procedure:____

Dr. ______________________________ has told me that I have the following medical condition ______________________________

that needs to be treated because ____.

The doctor has explained the operation/procedure to me and has told me:

1. All operations/procedures involve risks such as: severe loss of blood, infection, cardiac arrest, and death and about the specific and reasonably anticipated risks and complications of the proposed operation/procedure; the possible or likely consequences of the proposed operation/procedure. Risks specific to planned procedure:

____

____

____

____

2. There is no guarantee that this operation/procedure will improve my condition.
3. The operation/procedure will involve the administration of medications (conscious sedation) which may alter my level of consciousness and the benefits, risks, and complications have been explained. The operation/procedure will involve the administration of medications (deep sedation) which have a high risk for loss of protective reflexes and the benefits, risks, and complications have been explained.
4. I request that anything removed from me be disposed of by UPMC Hamot as usual, with the following exceptions (if none, so state):

____

5. About feasible alternative treatments and the risks involved with those.
6. The anticipated outcome, if no treatment is received.

The doctor has explained to me that sometimes during or after an operation or procedure unforeseen conditions or complications are encountered. If such circumstances occur during my operation or procedure, I consent to the performance of such additional treatment and procedures as my doctor determines to be medically necessary or in my best interest in the exercise of his or her professional judgment. In addition, if such circumstances occur after my operation or procedure, I (i) authorize my doctor or his or her designee to return me to the operating room to repeat or modify my initial operation or procedure, and (ii) I consent to such repeat or modified operation or procedure and treatment as my doctor or his or her designee believes is medically necessary or in my best interest in the exercise of his or her professional judgment, and (iii) I waive any requirement on his or her part to delay the repeat or modified operation or procedure or treatment in order to obtain my consent, regardless of whether or not I am unable to give such consent at that time.

The doctor has also explained to me that during the course of my treatment, it may be necessary for me to be returned to the operating room for procedures such as the replacement of a wound vacuum device or the irrigation and debridement of my wound. I (i) authorize my doctor or his or her designee to return me to the operating room for such procedures, and (ii) I consent to such procedures as my doctor or his or her designee believes is medically necessary or in my best interest in the exercise of his or her professional judgment, and (iii) I waive any requirement on his or her part to delay the procedures in order to obtain my consent, regardless of whether or not I am unable to give such consent at that time.

Patient Signature ____ Date: _____/_____/_____ Time: ______:______

The patient was unable to consent because ____.

I, therefore, consent for the patient ______________________________________ Date: _____/_____/_____ Time: ______:______
(Signature / Relationship to Patient)

Staff witness signature ____ Date: _____/_____/_____ Time: __________

I declare that I personally explained the above operation/procedure risks and alternatives to the patient and/or the patient's guardian.

Physician Signature ____ Date: _____/_____/_____ Time: ______:______

FOR ALL INVASIVE PROCEDURES, DOCUMENT VERIFICATION OF CORRECT SITE.

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Consent for Treatment of Breast Disease

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I ____, acknowledge that my physician has advised me of the following:

1. Pennsylvania law requires physicians to obtain a separate written consent for a biopsy and/or surgical treatment of breast disease.
2. I understand that I must consent to any diagnostic procedures and treatments and have a right to refuse any or all options.
3. I understand that Options A (Breast Biopsy) and B, as set forth below, are separate and that I may sign either or both.

Option A: (State Right or Left) ____ **Breast Biopsy**

Signature of Patient: ____ **Date: ____/____/____ Time: ______ AM PM**

WHEN A PATIENT IS A MINOR OR IS INCOMPETENT TO GIVE CONSENT:

Signature of person authorized to consent for patient_____________________________________ Relationship to patient_________________________________

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Option B: If a biopsy determines or has determined that I have a tumor in my breast or other breast abnormality requiring surgery, then I authorize Dr. ____ to perform such operations or procedures, including breast removal, which are deemed necessary, I have been informed of currently accepted alternatives to radical mastectomy.

Procedure: ____

____

Signature of Patient: ____ Date: ____/____/____ Time: ______:______

WHEN A PATIENT IS A MINOR OR IS INCOMPETENT TO GIVE CONSENT:

Signature of person authorized

to consent for the patient: _____________________________________ Relationship to patient: ___________________________________

I declare that I personally explained the above operation/procedure risks and alternatives to the patient and/or the patient's guardian.

Physician's Signature: ____ Date: _____/_____/_____ Time:______:______

FOR ALL INVASIVE PROCEDURES, DOCUMENT VERIFICATION OF CORRECT SITE.