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I. CONSENT TO SURGERY OR SPECIAL PROCEDURE

FACILITY NAME: _____

I have been asked to read all of the information contained in this consent form and to consent to the procedure described below on behalf of _____ or
(fill in name of patient)

myself. I have been told that I should ask questions about anything that I do not understand. (If the decision-maker signing this form is not the patient, references to "I," "my" or "me" should be read as if referring to "the patient.")
I understand that the information in this consent form, in addition to discussions with my physicians and any other written materials they may provide, is intended to help me make an informed decision whether to voluntarily undergo the identified procedure.

Diagnosis: I understand that after being examined, treated, and having studies reviewed, I have been diagnosed as having:
_____

Recommended Procedure: I understand that my physician(s) have recommended that I undergo a procedure known as
_____

_____

I acknowledge that my physician(s) or physician representative has described the recommended procedure to my satisfaction including the risks and benefits of the procedure, alternative treatments, the risks and benefits of the alternative treatments, the likelihood of me achieving my goals; any potential problems that might occur during recuperation and the likely medical results should I decide not to undergo the recommended procedure. I have also been told that there are risks that may occur with any surgery even in healthy patients. These risks include, but are not limited to bleeding, which may require the use of blood or blood products, injury to adjacent organs including the spleen, stroke, heart attack, infection, death, cardiac arrest, brain and nerve damage (including paralysis, loss of function, and coma).
Additional risks: _____

_____

_____.

If needed, blood and/or blood products have the following general risks: reactions resulting in itching, rash, fever, chills, headache or shock; respiratory distress (shortness of breath); kidney damage; systemic bacterial infection; exposure to blood borne viruses including hepatitis (an inflammatory disease affecting the liver) and Human Immunodeficiency Virus (HIV, the virus that causes AIDS); and death. Alternatives to transfusion include the use of devices that filter and return blood lost in surgery to me or by providing medications that boost my blood count prior to an elective procedure. Bleeding and/or severe anemia could put my life in danger or cause permanent brain damage. I understand that substitutes for blood or plasma might not work well enough. Blood and/or blood products might offer the only chance to preserve my life.

☐ I refuse the transfusion of blood and/or blood products and understand that I will be asked to sign a separate form entitled, Release from Liability for the Refusal of Blood Transfusion.

If my procedure is to be performed in an Ambulatory Surgical Facility (ASF), the comparative risks, benefits and alternatives associated with performing the procedure in the ASF instead of a hospital have been fully explained to me.
I understand the hospital may require that all jewelry and/or body piercing hardware be removed prior to surgery.

Teaching Facility and Overlapping Surgeries: I understand that the facility is a teaching facility. The health care team may include residents, fellows, students, and skilled healthcare professionals. Credentialed team members may perform all or parts of my procedure under the supervision and guidance of my physician(s). My attending physician may also be caring for one other patient during my surgery, but remains responsible to me and will perform or be present for the key portions of the procedure. If unanticipated circumstances require my surgeon to be unavailable during my surgery, another qualified surgeon will promptly come to the operating room. Representatives of medical device companies may be present to provide

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devices, and observe and advise on their use. Who will participate and in what manner will be decided at the time of the procedure and will depend on the availability of individuals with the necessary expertise and on my medical condition.
Representatives of medical device companies may be present to provide devices, and observe and advise on their use. Who will participate and in what manner will be decided at the time of the procedure and will depend on the availability of individuals with the necessary expertise and on my medical condition. If an accidental exposure to my blood or body fluids occurs to staff during the surgery or procedure I agree to blood tests for hepatitis B, hepatitis C and HIV.
I understand that the physician(s) or others may choose to photograph, televise, film or otherwise record all or any portion of my procedure for medical, scientific or educational purposes. I consent to the photographing, televising, filming or other forms of recording of the procedure(s) to be performed, including appropriate portions of my body,
body functions or sounds, provided my identity is not revealed. I understand and agree that 1) any photographs, films, or other audio or visual recordings created will be the sole property of the facility: and 2) the facility or any appropriate staff member may edit, preserve, or destroy all or any part of the photographs, films, or other audio or visual recordings. Such recordings are not part of the medical record and I understand I cannot obtain a copy. I authorize the disposal or retention, preservation, testing, or use for scientific, educational or other purposes of all or any portion of specimens, tissues, body parts, or other things, including prostheses and medical/surgical appliances, that may be removed from my body. I understand that if any medical device, as defined by federal regulations, is implanted in a patient's body, the facility is required by law to report to the manufacturer the name, address and social security number of the patient and the description and identity of the device.

MY SIGNATURE BELOW ACKNOWLEDGES THAT:

1. **I have read (or had read to me), understand and agree to the statements set forth in this consent form.**
2. **A physician has explained to me all information referred to in this consent form. I have had an opportunity to ask questions and my questions have been answered to my satisfaction, including any question I have about the potential use of blood and/or blood products and any risks regarding their use.**
3. **All statements requiring completion were filled in before I signed.**
4. **No guarantees or assurances concerning the results of the procedure(s) have been made.**
5. **I am signing this consent voluntarily. I am not signing due to any coercion or other influence.**
6. **I hereby consent and authorize Dr. _____(my physician(s)) and/or those associates, assistants and other health care providers designated by my physician(s) to perform the recommended procedure described above. I understand that during the course of the procedure, conditions may become apparent that require my physicians or their designees to take steps or perform additional procedures that they believe are medically necessary to achieve the desired benefits or for my well-being. I authorize and request my physician(s) or their designees to perform whatever medical acts or additional procedures they, in the exercise of their sole professional judgment, deem reasonable and necessary, and I waive any obligation on their part to stop or delay the continuation of my procedure in order to obtain additional consent if I am unable to give additional consent at that time.**

_____ _____
Witness Signature of patient or person authorized to consent for patient

_____ _____ _____
Date Time Relationship to patient if signer is not patient

I have explained to the patient signing above all of the information referred to in this consent form. I have given no guarantee or assurance as to the results that may be obtained.

____ _____ _____
Date Time Signature of Physician

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INTERPRETER'S STATEMENT

Execute if an interpreter is provided to assist the individual in understanding this informed consent form:

I have translated the information and advice presented orally to the individual to be treated by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____

Cyracom ID (if applicable)

_____

Print Name

_____

Signature (Not required if a Cyracom Interpreter Was Used)

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II. CONSENT TO PROCEDURAL/MODERATE SEDATION
MY SIGNATURE BELOW ACKNOWLEDGES THAT:

The physician responsible for my anesthetic or his designee will provide moderate to deep sedation (the administration of drugs to cause a decreased level of consciousness) intravenously (through my veins) to complete the procedure with greater ease and comfort. I may still be able to follow verbal commands, but will not be fully aware of my surroundings.

1. I understand that the physician responsible for my anesthetic will determine the type of anesthesia to use based upon the type of surgery or procedure and my individual medical and physical characteristics. I understand that during the surgery or procedure it may be necessary to alter the type of anesthesia provided based upon my medical condition and/or conditions related to the surgery/procedure.
2. A physician or physician's representative has explained to me the nature, purpose, risks/consequences of the planned sedation and alternative methods of anesthesia, if any (including the risks of those alternatives).
3. I understand sedation involves risks in addition to the risks of the procedure itself, which may include the following; hypoventilation (inadequate breathing), respiratory arrest (lack of breathing), low blood pressure and/or adverse drug reaction. Additional medical care may be necessary including the administration of additional medications and/or inserting a tube into my throat to assist with ventilation (breathing).
4. I understand that there are occasions when safety precludes administration of sufficient medication to prevent recall of portions of the procedure.
5. I understand that the facility is a teaching facility and that residents, fellows, students and others may assist with or perform all or parts of the administration of sedation or performance of medical acts as deemed appropriate by and under the supervision of the procedure physician.
6. I am aware that the practice of medicine is not an exact science. I understand no guarantee or assurance can be made as to results that may be obtained.
7. I consent to the administration of such anesthetics/sedatives as may be considered necessary or advisable by the health care providers.

Background: Pennsylvania law requires that in most non-emergency circumstances, a minor may only be prescribed opioid medications (morphine-like drugs) if the prescriber first discusses the potential risks associated with the medication with the minor and also with the minor's parent, guardian, or an adult who has a valid health care proxy to consent to the minor's medical treatment. This consent form memorializes that the prescriber discussed the risks associated with opioid medications with you and the minor-patient. Please review the information listed and put your initials next to each item after you and the minor –patient have discussed the risks with the prescriber and feel you understand and accept what each statement says.

As the responsible prescriber, I certify that I have discussed with both the minor, as well as the minor's parent/guardian/authorized adult the following items: Adult Initials

(i)The risks of addiction and overdose associated with the controlled substance containing an opioid _____
(ii)The increased risk of addiction to controlled substances to individuals suffering from mental or substance use disorders. _____
(iii)The dangers of taking a controlled substance containing an opioid with benzodiazepines, alcohol or other central nervous system depressants. _____
(iv)Any other information in the patient counseling information section of the labeling for controlled substances containing an opioid that I deemed necessary. _____

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_____ _____ _____
Date Time Signature of Patient or Decision-maker

_____
Relationship if signer is not patient

_____
Witness

The patient has indicated that the preceding information has been read and understood, and any questions about this information have been answered. I have given no guarantee or assurance as to the results that may be obtained.

_____ _____ _____
Date Time Signature of Physician or Physician's Representative

INTERPRETER'S STATEMENT

Execute if an interpreter is provided to assist the individual in understanding this informed consent form:

I have translated the information and advice presented orally to the individual to be treated by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Cyracom ID (if applicable)

_____
Print Name

_____
Signature (Not required if a Cyracom Interpreter Was Used)

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III. Consent to Deep Sedation for Diagnostic or Therapeutic Procedures

MY SIGNATURE BELOW ACKNOWLEDGES THAT:

The licensed independent practitioner responsible for my sedation or his designee will provide deep sedation (the administration of drugs to cause a decreased level of consciousness) intravenously (through my veins) to complete the procedure with greater ease and comfort. I will not be easily aroused and will not be fully aware of my surroundings. I understand I may require assistance in maintaining an open airway and spontaneous ventilation.

1. I understand that the licensed independent practitioner responsible for my deep sedation will determine the type of sedation to use based upon the type of procedure and my individual medical and physical characteristics. I understand that during the procedure it may be necessary to alter the type of sedation provided based upon my medical condition and/or conditions related to the procedure.
2. A physician has explained to me the nature, purpose, risks/consequences of the planned sedation and alternative methods of anesthesia, if any (including the risks of those alternatives).
3. I understand sedation involves risks in addition to the risks of the procedure itself, which may include the following; hypoventilation (inadequate breathing), respiratory arrest (lack of breathing), aspiration (stomach contents entering the lungs), low blood pressure and/or adverse drug reaction. Additional medical care may be necessary including the administration of additional medications and/or inserting a tube into my throat to assist with ventilation (breathing).
4. I understand that there are occasions when safety precludes administration of sufficient medication to prevent recall of portions of the procedure.
5. I understand that the facility is a teaching facility and that residents, fellows, students and others may assist with or perform all or parts of the administration of sedation or performance of medical acts as deemed appropriate by and under the supervision of the procedure physician.
6. I am aware that the practice of medicine is not an exact science. I understand no guarantee or assurance can be made as to results that may be obtained.
7. I consent to the administration of such anesthetics/sedatives as may be considered necessary or advisable by the health care providers.

Background: Pennsylvania law requires that in most non-emergency circumstances, a minor may only be prescribed opioid medications (morphine-like drugs) if the prescriber first discusses the potential risks associated with the medication with the minor and also with the minor's parent, guardian, or an adult who has a valid health care proxy to consent to the minor's medical treatment. This consent form memorializes that the prescriber discussed the risks associated with opioid medications with you and the minor-patient. Please review the information listed and put your initials next to each item after you and the minor –patient have discussed the risks with the prescriber and feel you understand and accept what each statement says.

As the responsible prescriber, I certify that I have discussed with both the minor, as well as the minor's parent/guardian/authorized adult the following items: Adult Initials

(i)The risks of addiction and overdose associated with the controlled substance containing an opioid _____
(ii)The increased risk of addiction to controlled substances to individuals suffering from mental or substance use disorders. _____
(iii)The dangers of taking a controlled substance containing an opioid with benzodiazepines, alcohol or other central nervous system depressants. _____
(iv)Any other information in the patient counseling information section of the labeling for controlled substances containing an opioid that I deemed necessary. _____

_____ _____

Witness

Signature of patient or person authorized to consent for patient

UPMC

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_____ _____ _____

Date Time Relationship to patient if signer is Not the patient

The patient has indicated that the preceding information has been read and understood, and any questions about this information have been answered. I have given no guarantee or assurance as to the results that may be obtained.

_____ _____ _____

Date Time Signature of Physician

INTERPRETER'S STATEMENT

Execute if an interpreter is provided to assist the individual in understanding this informed consent form:

I have translated the information and advice presented orally to the individual to be treated by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____

Cyracom ID (if applicable)

_____

Print Name

_____

Signature (Not required if a Cyracom Interpreter Was Used)

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IV. CONSENT TO ANESTHESIA

MY SIGNATURE BELOW ACKNOWLEDGES THAT:
I understand the following type of anesthesia will be administered in connection with the procedure discussed in Section I or the attached procedure specific consent:
_____.

I understand that the physician responsible for my anesthetic (anesthesiologist) will determine the type of anesthesia to use based upon the type of surgery or procedure and my individual medical and physical characteristics. I understand that during the surgery or procedure it may be necessary to alter the type of anesthesia provided based upon my medical condition and/or conditions related to the surgery/procedure.

1. A physician has explained to me the nature, purpose, risks/consequences of the planned anesthesia and alternative methods of anesthesia, if any (including the risks of those alternatives).
2. I understand anesthesia involves risks in addition to the risks of the procedure itself, which may include the following; death, cardiac arrest, cardiac arrhythmia, adverse drug reaction, corneal abrasion (scratch of the surface of the eye), damage to the nose, throat vocal cords, mouth, and esophagus(food tube), respiratory problems including pneumonia, pneumothorax, damage to arteries or veins, headaches, brain and nerve damage (including paralysis, loss of function, and coma), pain and discomfort in the area of a nerve block, and injury to mouth, teeth, or dental work. I have informed the anesthesiologist of any and all dentures, bridges, caps and crowns or other prosthetic devices I have that are removable, and I have removed them prior to going to surgery. I agree that responsibility for loss or damage will be mine if I fail to inform the anesthesiologist or fail to remove any and all removable dentures, bridges, caps, crowns, or other dental prosthetic devices prior to going to surgery.
3. I understand that some people may experience awareness of some or all of the events of a surgery or procedure and be able to recall these events even though general anesthesia is provided. The risk of this occurring is increased in people who have heart disease, those having emergency surgery or a cesarean section and in patients with a history of awareness during anesthesia or a history of high alcohol intake or chronic use of certain drugs, such as pain relievers. I have been encouraged to let my surgeon or anesthesiologists know if this happens to me.
4. I further understand that there are rare occasions when safety precludes administration of sufficient medication to prevent recall of portions of the procedure.
5. I understand that a certified registered nurse anesthetist (CRNA) may administer some or all of my anesthesia under the supervision of the anesthesiologist. Certified registered nurse anesthetists are registered nurses who have had additional concentrated education in the field of anesthesia and anesthesia care and are licensed in this specialty.
6. I understand that the facility is a teaching facility and that residents, fellows, students and others may assist with or perform all or parts of the administration of anesthesia or performance of medical acts as deemed appropriate by and under the supervision of the staff anesthesiologist(s).
7. I understand that data may be collected from my anesthesia record and hospital chart for statistical analysis and that these data and analyses may be published. The data in any such publication will be anonymous.
8. I am aware that the practice of medicine is not an exact science. I understand no guarantee or assurance can be made as to results that may be obtained.
9. I consent to the administration of such anesthetics as may be considered necessary or advisable by the health care providers.

Background: Pennsylvania law requires that in most non-emergency circumstances, a minor may only be prescribed opioid medications (morphine-like drugs) if the prescriber first discusses the potential risks associated with the medication with the minor and also with the minor's parent, guardian, or an adult who has a valid health care proxy to consent to the minor's medical treatment. This consent form memorializes that the prescriber discussed the risks associated with opioid medications with you and the minor-patient. Please review the information listed and put your initials next to each item after you and the minor –patient have discussed the risks with the prescriber and feel you understand and accept what each statement says.

As the responsible prescriber, I certify that I have discussed with both the minor, as well as the minor's parent/guardian/authorized adult the following items:

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Adult Initials

(i)The risks of addiction and overdose associated with the controlled substance containing an opioid _____

(ii)The increased risk of addiction to controlled substances to individuals suffering from mental or substance use disorders. _____

(iii)The dangers of taking a controlled substance containing an opioid with benzodiazepines, alcohol or other central nervous system depressants. _____

(iv)Any other information in the patient counseling information section of the labeling for controlled substances containing an opioid that I deemed necessary. _____

_____ _____

Witness

Signature of patient or person authorized to consent for patient

_____ _____ _____

Date Time

Relationship to patient if signer is not patient

The patient has indicated that the preceding information has been read and understood and any questions about this information have been answered. I have given no guarantee or assurance as to the results that may be obtained.

_____ _____ _____

Date Time

Signature of Physician

INTERPRETER'S STATEMENT

Execute if an interpreter is provided to assist the individual in understanding this informed consent form:

I have translated the information and advice presented orally to the individual to be treated by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____

Cyracom ID (if applicable)

_____

Print Name

_____

Signature (Not required if a Cyracom Interpreter Was Used)

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V. BLOOD OR BLOOD PRODUCTS CONSENT FORM

MY SIGNATURE BELOW ACKNOWLEDGES THAT:

I understand there will or may be a need for me to receive transfusion(s) of blood or blood products.

A physician or physician's representative has explained to me the nature, purpose and benefits of receiving blood or blood products; risks/consequences of receiving blood or blood products; the alternatives, if any, to such use (including the risks of such alternatives) and the consequences if no blood or blood products are used.

Benefits:

Blood transfusion is a life-saving treatment that benefits patients by treating or preventing blood loss, which can lead to a seriously low hemoglobin level and cause damage to body organs due to a lack of oxygen.

Risks:

I understand that among, or in addition to, other specific risks that may have been explained to me by the physician(s), the use of blood or blood products has the following general risks:

Uncommon (1-5%) chance)

- Mild reactions resulting in itching, rash, fever, headaches.

Rare (<1% chance)

- Respiratory distress (shortness of breath) or lung injury
- Exposure to blood borne micro-organisms (bacteria and parasites) that could result in an infection
- Possible effects on the immune system, which may decrease the body's ability to fight infection
- Exposure to blood borne viruses such as hepatitis B (an inflammatory disease affecting the liver)
- Shock

Extremely rare (one in a million or less)

- Exposure to blood borne viruses such as hepatitis C (an inflammatory disease affecting the liver) and Human Immunodeficiency Virus (HIV, the virus that causes AIDS)
- Death

Alternatives:

1. Intraoperative Cell Salvage:
   - I understand the in some instances, it may be possible to collect my own blood lost during surgery (intraoperative blood salvage) or shortly after surgery (postoperative blood salvage).
   - I understand that in some instances my own blood can be used to prepare platelet gel, autologous conditioned plasma, or bone marrow aspirate concentrate.

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2. Pharmacologic products:

- I understand that pharmacologic products may be given before surgery to stimulate production of certain blood cells by the body's natural processes.

☐ I refuse the transfusion of blood and/or blood products and understand that I will be asked to sign a separate form entitled, Release from Liability for Refusal of Blood Transfusion.

I acknowledge that patient education materials are available for my review. All blanks on this form were filled in before I signed. I am signing this consent voluntarily. I consent to the use of blood or blood products as deemed necessary by my physician(s).

_____ _____

Witness Signature of patient or person authorized to consent for patient

_____ _____ _____

Date Time Relationship to patient if signer is not patient

The patient has indicated that the preceding information has been read and understood, and any questions about this information have been answered. I have given no guarantee or assurance as to the results that may be obtained.

_____ _____ _____

Date Time Signature of Physician

INTERPRETER'S STATEMENT

Execute if an interpreter is provided to assist the individual in understanding this informed consent form:

I have translated the information and advice presented orally to the individual to be treated by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____

Cyracom ID (if applicable)

_____

Print Name

_____

Signature (Not required if a Cyracom Interpreter Was Used)