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FAX COVER SHEET

To: ORMC

From: Stephanie LeBlanc

Company:

To Fax Number: 8453331041

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Notes/Comments:

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Consent for Surgical/Invasive Procedures and Sedation

Pt. Label

I hereby give my consent and authorize: Dr. HARDCASTLE and those who he/she may designate as associates or assistants to perform upon me or the named patient the following operation/procedures: _____

Left Total Knee Arthroplasty

The nature, intended purpose, benefits, significant foreseeable risks, complications and consequences of such operation/procedure, as well as the alternatives if the above operation/procedure is not performed, have been explained and discussed with me by (Name of Physician) HARDCASTLE

I give permission with full knowledge and understanding thereof. I understand that medicine is not an exact science and that there is the possibility that the operation/procedure may not have the benefits or results intended. I am also aware that there are always risks and dangers to life and health associated generally with surgery, use of medication, medical procedures and treatments which can cause adverse consequences not ordinarily anticipated in advance, but I give this permission with full assent nevertheless.

It has been explained to me and I understand that during the course of the operation/procedure, unforeseen conditions may be revealed or encountered which necessitate surgical or other procedures in addition to or different from those contemplated. I therefore request and authorize the above named physician or his/her designees to perform such additional surgical or other procedures as are deemed necessary or desirable.

- I understand that the procedure may require that I undergo some form of sedation, which may have its own risks. Prior to my procedure my doctor will inform me of the course of sedation that is recommended (if any) along with its risks, benefits, discomforts, and potential complications.
- I consent to photographing, videotaping, televising or other observation of the operation/procedure/treatment as may be purposeful for the advance of medical knowledge and/or education, with the understanding that my/the patient's identity remain anonymous and all photographs and videotapes remain the property of ORMC and/or the responsible physician.
- I consent to the presence of Vendors/Salespersons/Students during the procedure/operation.
- I consent to the administration of blood/blood components if deemed necessary. The Surgeon has explained to me the need for, risks of and alternatives to a blood transfusion if blood or blood components are needed.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the procedure(s) specified above.

I further grant permission for the use of such tissues and/or organs as it may be necessary to remove during the procedure, for purposes of pathological diagnosis and thereafter for the advancement of medical science and education, and their disposal, at this Hospital or at such other institution as this Hospital may designate.

2/3/2020 ¹⁰AM X Helen Masker
(Date) (Time) (Patient/Health Care Agent/Surrogate/Guardian Signature)

Helen Masker self
(Printed Name) (Relationship to Patient)

2/3/2020 ^{10AM}PM [Signature]
(Date) (Time) (Witness Signature)

Stephanie LeBlanc
(Printed Name)

Mark this box if telephone consent

Mark this box if interpreter was involved

Interpreter ID # _____

I have discussed the nature and purpose and the reasonably foreseeable risks and benefits of the procedure, the alternatives, including not performing the procedure, as well as the risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

2/3/2020 ¹⁰PM [Signature]
(Date) (Time) (Signature of Physician Appropriately Credentialed Practitioner Providing Explanation)

HARDCASTLE
(Printed Name)

