Patient Name: ____________________________________

Date of Birth: ____________________________________

Medical Record #: ____________________________________

Place Patient Label

RUSH UNIVERSITY MEDICAL CENTER

GENERAL INFORMED CONSENT

Consent-E
General Informed Consent

IDN13150039

1. I hereby authorize ____________________________________ and/or ____________________________________ and/or such assistants and associates as may be selected by him/her/they to perform the following procedure(s)/treatment(s) upon myself/the patient.

   Procedure(s)/Treatment(s) ____

   ____

   ____

2. I understand that this procedure(s)/treatment(s) appears indicated by the diagnostic and/or clinical observations performed. I have been informed of the following:
   - A description of the proposed procedure/treatment
   - The indications for the proposed procedure/treatment
   - Material risks and benefits for the patient related to the treatment based on the available clinical information and dependent upon the professional custom and standard.
   - The likelihood of the patient achieving his or her goals.
   - Treatment alternatives, including the attendant material risks and benefits
   - The probable consequences of declining the recommended or alternative therapies
   - Who will provide the procedure/treatment
   - When indicated, any limitations on the confidentiality of information learned from or about the patient

   I understand the information provided and give this consent voluntarily.

3. I authorize the administration of blood and blood products to myself/the patient as may be considered necessary or advisable in connection with the above described procedure(s)/treatment(s) both during the procedure and for the remaining period of hospitalization of myself/the patient. I have been informed of the potential benefits, risks or alternatives to receiving blood and blood products.
4. I authorize the administration to myself/the patient of anesthetics determined to be necessary or advisable by the physician responsible for administering or for supervising the administration of anesthetics. I acknowledge that I have read and fully understand the patient information sheet provided me about anesthesia services or have otherwise been fully advised about, and understand, the nature and purpose of the anesthesia, the possible risks and complications and possible alternative anesthesia methods.
5. I have informed the licensed health care provider that to my knowledge I have allergies to the following substances and drugs:

   (If none, leave blank) ____

6. I understand that some physicians who may be treating me or the above-noted patient are not employees or agents of Rush University Medical Center but are independent medical practitioners who are solely and exclusively responsible for the exercise of their medical judgment.
7. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure(s)/treatment(s).
8. I consent to the photographing or televising of the procedure(s)/treatment(s) to be performed, including appropriate portions of my/the patient's body, for medical, scientific or educational purposes, provided my/his/her identity is not revealed by the pictures or by descriptive texts accompanying them.
9. For the purpose of advancing medical education, I consent to the admittance of observers to the room in which the procedure(s)/treatment(s) is performed. Such observers may be health care professionals, students, clinical device specialists or others as may be identified by my physician/health care provider.
10. I consent to the disposal by Medical Center authorities of any tissues or body parts which may be removed.

(OVER)

RUSH UNIVERSITY MEDICAL CENTER

PATIENT INFORMATION
ABOUT ANESTHESIA SERVICES

The purpose of this document is to provide written information regarding the anesthesia services that will be needed for the operation, diagnostic or therapeutic procedure that your doctor has scheduled. The type of anesthesia is determined by many factors, including your physical condition, the type of procedure your doctor has planned, the preference of your doctor and your anesthesiologist, as well as your own desire. Sometimes an anesthesia technique that involves the use of local anesthetic drugs, with or without sedation, may not succeed completely, and therefore another technique may need to be used, including general anesthesia. The type(s) of anesthesia most likely to be used for your procedure is (are) checked below, and your anesthesia will be administered by licensed personnel credentialed and/or privileged based on the scope of practice. If medically necessary, an alternate type of anesthesia may be used, as deemed appropriate by the anesthesiologist. Regardless of the type of anesthesia, your vital signs will be closely monitored during the procedure.

If you have questions about the information provided herein about anesthesia, please discuss with the anesthesia personnel who will evaluate you prior to your scheduled procedure. If you need to discuss concerns about anesthesia earlier than the day prior to your procedure, you can call the pre-anesthesia evaluation clinic at (312) 942-1785.

☐ **General Anesthesia**	Expected Result	Total unconscious state, possible placement of a tube into the windpipe.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes.
	Risks (include but not limited to)	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, vomiting, aspiration, pneumonia.
☐ **Spinal or Epidural Analgesia/Anesthesia** ☐ With sedation ☐ Without sedation	Expected Result	Temporary decrease or loss of feeling and/or movement to lower part of the body.
	Technique	Drug injected through a needle/catheter placed either directly into the fluid of the spinal canal or immediately outside the spinal canal.
	Risks (include but not limited to)	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels.
☐ **Major/Minor Nerve Block** ☐ With sedation ☐ Without sedation	Expected Result	Temporary loss of feeling and/or movement of a specific limb or area.
	Technique	Drug injected near nerves providing loss of sensation to the area of the operation.
	Risks (include but not limited to)	Infection, convulsions, weakness, persistent numbness, residual pain requiring additional anesthesia, injury to blood vessels. If you receive a nerve block that affects any part of your leg, we recommend that you have a responsible adult assist you in moving around for 24 hours. Pain relief from a nerve block can wear off quickly, so oral pain medication should be taken before the onset of pain.
☐ **Intravenous Regional Anesthesia** ☐ With sedation ☐ Without sedation	Expected Result	Temporary loss of feeling and/or movement of a specific limb.
	Technique	Drug injected into veins of arm or leg while using a tourniquet.
	Risks (include but not limited to)	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels.
☐ **Monitored Anesthesia Care** (with sedation)	Expected Result	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes, producing a semi-conscious state.
	Risks (include but not limited to)	An unconscious state, depressed breathing, injury to blood vessels.
☐ **Monitored Anesthesia Care** (without sedation)	Expected Result	Measurement of vital signs, availability of anesthesia provider for further intervention.
	Technique	None.
	Risks (include but not limited to)	Increased awareness, anxiety and/or discomfort.

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11. I have read the information sheet entitled (if no information sheet is provided, leave blank).

____

12. I acknowledge that I have read and fully understand this document and that if I have questions I have had the opportunity to have them answered by the physician / health care provider.

Date: ______________________________________

Time: ______________________________ A.M. / P.M.

____
Signature of Consenting Party

____
Print Name

WITNESS TO SIGNATURE OF CONSENTING PARTY:

____
Signature of Witness

____
Print Name

IF CONSENTING PARTY IS OTHER THAN PATIENT:

____
Signature of Consenting Party

____
Print Name *Relationship*

INFORMED CONSENT AFFIRMATION

My signature below affirms that prior to the time of the procedure, I provided to the patient and/or his/her guardian the information contained in paragraph 2 above verbally, by means of an information sheet and/or other audio/visual means of communication.

Date: ______________________________________

Time: ______________________________ A.M. / P.M.

____
Signature of Licensed Health Care Provider

____
Print Name

TELEPHONE CONSENT

Verbal authorization for the procedure(s) / treatment(s) in paragraph 1 above was obtained from the consenting party named below who has stated that he / she has authority to consent on behalf of the patient following an explanation of the information in paragraph 2 above.

Date: ______________________________________

Time: ______________________________ A.M. / P.M.

____
Print Name of Consenting Party

____
Relationship to Patient

WITNESS AND RECIPIENT OF CONSENT:

____
Signature of Witness

INSTRUCTIONS: This consent form should be signed by the patient if an adult (18 years and older), by a parent or court-appointed guardian if the patient is a minor or by a court-appointed guardian if the patient has been declared legally incompetent.