BOSTON MEDICAL CENTER

1000545

AFFIX PATIENT LABEL

or

Patient Name _____

Surgeon Name _____

MRN/DOB _____

Consent To Procedure/Operation
Post-partum Dilation and Evacuation

I, _____ , hereby authorize my
(Name of patient/legal guardian)

doctor _____ together
(Name of physician, dentist or surgeon in charge)

with such assistants as he/she may designate, as well as other individuals who are required to participate in the procedure/operation who may not be known at this time but include individuals on Page 2 to perform the following procedure/operation:

Post-partum Dilation and Evacuation: removal of tissue from the uterus.
(Name of Procedure/Operation and Brief Description)

The names and positions of these individuals participating in the procedure/operation will be recorded in the medical record. I understand that I may request a copy of my medical record.

I also authorize any additional operations or procedures that are considered necessary on the basis of findings during the course of said procedure/operation. Any tissues or parts surgically removed may be disposed of by Boston Medical Center in accordance with accustomed practice.

The nature, extent, and purpose of the operation, possible alternative methods or treatment (including choosing no treatment), the risks involved, and the possibility of complications have been fully explained to me. I understand that there is a chance that major risks or complications of the procedure may occur, including but not limited to:

infections, bleeding, puncture of uterus, damage to bowel, bladder, failure to remove all tissue, continued bleeding, possible need for a second procedure or additional medication, possible hysterectomy (removal of uterus), death.

I acknowledge that no guarantee has been made as to the results of this procedure/operation.

I understand my doctor may need to leave the operating room during my procedure/operation. My doctor/surgeon has explained and answered all of my questions regarding potential absences.

I understand that this procedure/operation may have educational or scientific value. If clinical filming (recording by photography, video, electronic or audio media) will occur, I must be informed in advance by my clinician about the usage and purpose of the clinical filming prior to the filming whenever possible. I understand that I have the right to refuse any clinical filming.

I consent to the administration (transfusion) of blood or blood products during this procedure/operation or in the immediate post-operative period, should they be indicated. I am aware that this involves additional risks, including but not limited to: fever and allergic reactions, transmission of diseases such as hepatitis, HIV/AIDS and cytomegalovirus, and fluid overload.

If you refuse the use of blood or blood products: The risks of refusal of blood or blood product transfusion, if they are deemed necessary during the proposed procedure/operation, were explained to me by my physician/surgeon. I understand that my refusal to accept a blood transfusion, should it become necessary during or immediately after this procedure/operation, may place me at a higher risk for complications or catastrophic consequences that include but are not limited to: brain damage, heart attack, stroke, kidney failure (dialysis), prolonged intubation, permanent disability, and death. Nonetheless, I refuse the transfusion of blood or blood products.

Patient Initials: _____

I understand that it is possible that one or more healthcare industry professionals (technical representatives for medical equipment and device companies) may be present during this procedure/operation for advisory purposes related only to a product.

If sedation will be used during this procedure/operation to control my pain, I understand that this method of pain control has risks. These risks include but are not limited to: decreased blood pressure that may require intravenous fluids and/or medications and difficulty breathing that may require breathing support. The most common side effects

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of sedation are nausea and vomiting. In rare cases, there can be allergic reactions or cardiac arrest (stopping of the heart). I understand that I may have pain, even after receiving sedation.

I certify that I have read and fully understand the above consent, that explanations have been made, and that the physician/surgeon has answered all of my questions. I consent to this procedure/operation.

MUST RECORD DATE/TIME

Sign Name: _____ Print Name: _____ Date: _____ Time: _____
Patient

Sign Name: _____ Print Name: _____ Date: _____ Time: _____
Parent/Guardian Surrogate (if applicable)

Sign Name: _____ Print Name: _____ Date: _____ Time: _____
Provider/Physician/Surgeon

I interpreted the provider's explanation. (Interpreter must sign below, if applicable)

Sign Name: _____ Print Name: _____ Date: _____ Time: _____

				UPDATED DAY OF PROCEDURE/ OPERATION, IF APPLICABLE		
	Participant	**Name**	**Year**	**Patient Initials**	**Date**	**Time**
☐	Fellow					
☐	Resident					
☐	Physician Assistant					
☐	Certified Nurse Midwife					
☐	Certified Nurse Practitioner					
☐	Other					

				UPDATED DAY OF PROCEDURE/ OPERATION, IF APPLICABLE		
	Participant	**Name**	**Year**	**Patient Initials**	**Date**	**Time**
☐	Fellow					
☐	Resident					
☐	Physician Assistant					
☐	Certified Nurse Midwife					
☐	Certified Nurse Practitioner					
☐	Other					