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PATIENT CONSENT TO PROCEDURE -
CHOLECYSTECTOMY

Date \_\_\_\_\_ Time \_\_\_\_\_ A.M. P.M.

1. I give permission to Dr. \_\_\_\_\_, hereafter referred to as the physician, and the assistants he/she may select to treat the conditions which are believed to be present as indicated by his/her best judgment and the diagnostic tests already performed: cholecystitis (inflamed, infected gallbladder), cholelithiasis (stones in the gallbladder).

2. The procedures necessary to treat my condition have been explained to my satisfaction by the physician and I understand them to be: laparoscopic cholecystectomy (removal of the gallbladder using a camera inside the abdomen and several small incisions), intraoperative cholangiogram (x-ray of the bile duct with contrast), possible open laparotomy (accessing the abdomen via a larger incision).

3. During my operation, unexpected conditions may be found which require a change in the planned procedure. I authorize my physician to request consultation, if he/she believes it is necessary, and perform the surgical procedures that he/she deems advisable.

4. I have been informed of certain risks and possible consequences associated with the procedures listed in Paragraph 2. These include, but are not limited to: infection, bleeding, injury to nearby structures, conversion to open procedure, wound complications, bile leak, retained gallbladder stone.

5. I am aware of other risks such as severe bleeding, the need for blood transfusion(s), heart irregularity or stoppage, etc. Any complication may require a prolonged hospitalization, a modified incision or additional surgery.

6. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of my operation or procedure.

7. I consent to the disposal by hospital authorities of any tissue or body parts which may be removed at operation.

8. I authorize my physician to make video recordings for my medical record, for purposes of medical research, or for education as he/she deems advisable.

9. I authorize the admittance of those observers to the Operating Room who are approved by my physician.

10. I am aware that I may ask any desired questions about these procedures but do not wish to request further explanation at this time.

11. I have been informed by my physician to alternatives to the above proposed procedure.

12. Other: \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date/Time \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date/Time \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date/Time \_\_\_\_\_