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PATIENT CONSENT TO PROCEDURE - LAPAROSCOPIC-ASSISTED COLECTOMY

Date ____________________________ Time _______________________ _____ A.M. _____ P.M.

1. I give permission to **Dr. Carroll**, 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:

2. The procedures necessary to treat my condition have been explained to my satisfaction by the physician and I understand them to be: **laparoscopic-assisted right colectomy (removal of a portion of the large intestine via several small incisions and a camera, and examination of the removed intestine by pathologist)**.

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: **bleeding, infection, injury to nearby structures, wound complications, recurrence of condition named above, leakage at anastomosis (where the intestines are re-attached), conversion to open procedure, possible ostomy placement (pulling part of the intestine through an incision in the abdominal wall and suturing it in place).**

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 _______________________