Loyola University Medical Center
Consent for Surgery

Name: ______________________

MR#: ______________________

1. I hereby authorize ____________________, attending physician, and such assistants and associates as may be elected by him/her to perform the following procedure(s) upon: ____________________________

Patient’s Name

Procedures: Radical Cystectomy, Bilateral Pelvic Lymphadenectomy, Urinary Diversion

(removal of bladder, uterus, upper vagina, regional lymph nodes, other structures if necessary and reconstruction of urinary system with intestine)

2. I understand that this procedure(s) appears to be indicated by the diagnostic studies and/or clinical observations already performed regarding the following condition:

Condition requiring the procedure(s): bladder tumor

3. I authorize the administration of anesthesia as may, in the exercise of good professional judgment, be necessary or advisable by the physician responsible for administering anesthetics.

4. I authorize the administration of blood and blood components as may be considered necessary or advisable in connection with the procedure(s) described above.

5. The nature, purpose, and possible complications of the procedures and medical services described above, the risks and benefits reasonably to be expected, and the alternative methods of treatment and the risks/benefits of no treatment have been explained to me by my physician.

Possible Complications: bleeding, infection, urine/bowel leak, damage to other organs/ intestines/ blood vessels/ nerves, bowel obstruction, hernias, scar tissue formation, urinary obstruction, blood clots, inability to remove all of the tumor, incontinence, recurrence of cancer, need for additional procedures, alteration in bowel function (constipation/ diarrhea), risks of anesthesia (stroke, heart attack, death)

6. I recognize that during the operation unexpected conditions may be revealed which require my doctors to perform additional or different procedures than those described above. Since I may be under anesthesia or otherwise unable to give my consent to this treatment during the procedure(s) described above, I hereby authorize and request that the physician performing these procedure(s) and his assistants or designees perform such other procedures as are, in the exercise of good professional judgment, necessary and desirable. I understand that these procedures may include surgery as well as other forms of treatment. The authority granted in this paragraph shall extend to remedy all conditions found during the operation that require treatment, and that are not known at the time the procedure is commenced.

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.

8. I consent to the filming or recording of the procedure to be performed, including appropriate portions of my body, for scientific or educational purposes which are not related to diagnosis or treatment of my condition, provided my identity is not revealed by the pictures or by descriptive texts accompanying them. I understand that I can revoke this consent for filming/recording by notifying my attending physician within five days of my surgery or procedure. In the event of revocation, I understand that any prior us of film or recordings up to the date of revocation may not be retracted.

9. For the purpose of advancing medical education, I consent to the participation of residents, fellows and health care students in the surgery or procedure and to the admittance of observers to the room in which the surgery or procedure(s) are performed. These observers may include representatives from medical device manufacturing companies who are demonstrating or providing technical support for new procedures or equipment.

10. I consent to the disposal by hospital authorities of any tissues, body parts or implants which may be removed.

11. I acknowledge that I have read this document in its entirety and that I fully understand it, that all blank spaces have been completed and that any disagreeable sections have been crossed off and initialed prior to my signing.

12. I understand that I have the right to cancel my surgery at any time, even after I have signed this consent form. I understand that I am under no obligation to proceed with the surgery.

13. I have had a full discussion about the proposed procedure with my physician and have consented to the procedure described on this form. I further understand that if I have questions about my proposed surgery or procedure, I have the right to have those questions answered before the surgery or procedure.

Date ________________________ Time _______________________ Print Name ______________________ Signature of Patient ______________________

Print Name ______________________ Signature of Consenting Party ______________________ Relationship to Patient ______________________
AFFIRMATION OF INFORMED CONSENT BY PHYSICIANS

I have informed the above-named patient or the patient’s authorized representative, of the condition requiring treatment(s), therapy(s) or procedure(s) described to on the front page of this Consent form and I have, consistent with my best medical judgment, fully explained the nature and purposes of all the treatment(s), therapy(s) or procedure(s), possible alternative methods of treatment(s), therapy(s) or procedure(s), the risks involved and the possibility of complications in the treatment(s), therapy(s) or procedure(s) consented to and in alternative treatment(s), therapy(s) and procedure(s), and that, after the foregoing information had been explained, the patient or representative indicated that he/she understood that information and consented to such treatment(s), therapy(s) or procedure(s).

Date

INTERPRETER

I affirm that I acted as interpreter or translator for the patient or the patient’s representative and accurately and completely translated into the ______________________language both the statements contained on this form as well as the statements made by the physician, ______________________, to the patient and/or the patient’s representative and that the patient or the patients representative stated that he or she understood all of the statements and consented to the treatment and/or other procedures described in those statements.

Date

Relationship to Patient

Print Name

Patient ☐ or Consenting Party ☐ signed this form in my presence ☐ or consented by telephone ☐
If an RN is witnessing the signature, a properly executed Consent Progress Note must be in the medical record. ☐

Witness (print name and title) Signature Date

Additional Witness (For telephone consent, interpreter or, translator or if patient signs with an “X”) Signature Date