Good Samaritan Medical Center

Steward

CONSENT TO AN OPERATION

1. I authorize the performance upon myself, of the following operation:

   Dilation&Curettage (D&C), Hysteroscopy, Removal of any diseased tissue (Resection/Ablation)_____(the "Operation")

   (State nature and extent of diagnosis procedure and/or medical treatment)

   to be performed under the direction of the Attending Physician, **Dr Hanjani** ("My Doctor").

2. The nature, purpose, risks and benefits of the Operation, the possible alternative methods of treatment (and risks/benefits associated with those alternatives) as well as risks and benefits of not undergoing the procedure have been explained to me by My Doctor and to my complete satisfaction. No guarantee or assurance has been given by anyone as to the results that may be obtained. The **risks**, include, but are not limited to: Risks of bleeding, possibly requiring transfusion. Infection. Damage to surrounding structures e.g.: bladder, bowel, nerves, ureter, possibly requiring repair. Uterine perforation. Failure of procedure to obtain desired results. Possible need for further surgery, including laparoscopy or laparotomy (Open surgery). Possible vascular or respiratory complications, e.g.: blood clots, pneumonia.
3. I acknowledge that I have been afforded the opportunity to ask any questions with respect to the operation and any risks or complications thereto and to set forth, in the space provided below, any limitations or restrictions with respect to this consent: None

   _____
4. I consent to the performance of operations, procedures and treatment in addition to the Operation as a result of presently unforeseen conditions, which My Doctor/Associates/Assistants may in their judgment consider necessary or advisable in my present illness.
5. I consent to the photographing of the Operation to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying the pictures.
6. I acknowledge that other members of the medical/hospital staff will assist and consent to the admittance of observers into the operating/treatment room and the participation of trainees for the purpose of advancing medical education, who may assist My Doctor with the Operation associated with this consent, as listed here or made known to me in an Informed Consent Update prior to my procedure or as documented in my medical record for my reference.

   *Name of Resident/Fellow/Staff who will be participating: _____
7. I consent to the presence of vendor representatives, in the operative room, if My Doctor requests information on the vendor's products.
8. I consent to the disposal by hospital authorities of any tissue, organ or body parts which may be removed during my procedure.
9. If I received an implant medical device that is tracked in accordance with Section 519(e) of the Safe Medical Devices Act of 1990 (21 CPR 821) or on the request of the manufacturer, I understand that my name, address, telephone number and social security number will be provided to the device manufacturer.
10. I understand that during the operation human or synthetic tissue and/or allograft may be used. The risks and adverse consequences of accepting or refusing human tissue/ allograft material as they apply in my case have been fully explained to my satisfaction. Additional risks, complications, benefits or alternatives associated with the allograft that are not specified in this document were explained by my surgeon his/her assistants, or his/her designees
11. I have been informed that circumstances may arise during my treatment at the hospital that may make it necessary for me to receive a transfusion of blood and/or blood products (e.g., Red blood cells, Plasma, Cryoprecipitate, and Platelets).
    a. The benefits, risks and alternatives of accepting blood and/or blood product(s) transfusions as they apply in my case have been fully explained to me by my physician.
    b. I understand that the hospital has taken necessary and reasonable precautions in providing the blood and/or blood products to be used for my transfusion. However, these measures cannot eliminate the risk of infection or adverse occurrence, and no guarantees regarding the outcome of my transfusion can be or have been made.

Patient initials acceptance: _ _ Patient refused _ _ Not applicable _

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR THE OPERATION AND RECEIVED SUFFICIENT EXPLANATION OF THE OPERATION. I HAVE HAD THE OPPORTUNITY TO ASK ALL OF MY QUESTIONS AND HAVE ALL MY QUESTIONS ANSWERED WITH RESPECT TO THE OPERATION
I CONFIRM THAT INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.

Date/Time Patient Signature

When a patient is not able to consent for his/herself, complete the following:

Date/Time Name of the responsible person Signature Relationship to patient

Interpreter and Translation Services were offered and provided to me: YES_ _ NO___ NA_

Date/Time Interpreter Name Signature of Interpreter

The foregoing consent was read, discussed and signed in my presence and in my opinion the person(s) signing did so freely with full knowledge and understanding.

Soheil Hanjani MD, FACOG, FACS

Date/Time Name of the Attending Physician Signature of Attending Physician