Consent for Surgery or Procedure (Enterprise)

1. I (Print patient's name) _____
   a. Agree that I will have (include the medical term and patient words if desired):

   _____

   _____

   _____

   _____

   Possible risks include: pain, infection, bleeding, nerve injury, blood vessel injury, muscle damage, arthritis, stiffness, hardware failure, wound complications, need for further surgery, deep vein thrombosis, pulmonary embolism, loss of limb, death.

   b. At Sanford USD Medical Center, Sioux Falls, SD (fill in facility location)
   c. This will be done or supervised by: Nathan Skelley, MD (fill in provider name)
   d. My provider may have help from others. Help could include opening and closing the wound, cutting out tissue or implanting devices. I have been told who will help, if known. The key members that will assist will be listed on the procedural report.

2. **I have talked to my Provider or health care team about:**
   a. What the procedure or treatment is and what will happen.
   b. How it may help me (the benefits); possible improvement of pain and function.
   c. How it might harm me (the most likely and most serious risks).
   d. The long-term effects it might have.
   e. My other choices for procedure or treatment. The risks and benefits of those choices.
   f. What will likely happen, if I say "no" to this procedure or treatment. Continued non-operative treatment.
   g. How I might feel right after and how quickly I can expect to recover.
   h. The administration of sedation and/or local anesthesia as may be advisable or necessary for my comfort and safety.

3. I agree that: **(If I do not agree with a statement, I have crossed it out and initialed next to it.)**
   a. I have been told how likely it is that I will need a blood transfusion. I know the risks and benefits of receiving blood products. My provider and I have talked about other options. I will sign the blood transfusion consent if it is likely that I will need blood.
   b. If a staff person is exposed to my blood or body fluids, my blood will be drawn and tested for HIV and hepatitis. The test results will go:
      To me via my medical record;
      To the exposed worker. This is to decide if treatment for the worker is needed.
      To the employee Health Services Department and/or Infection Control at this facility; and
      To Department of Health as required by law.
   c. A urine pregnancy test will be completed for elective procedures involving moderate or deep sedation, or general anesthesia for all menstrual females unless past hysterectomy or past bilateral oophorectomy.

Consent for Surgery or Procedure (Enterprise)

4. **I understand that:**
   a. I can change my mind. If I do, I must tell the provider or team as soon as possible.
   b. The team members may change during the procedure.
   c. The team will double check my name and date of birth several times to ensure my safety.
   d. No one has promised me definite results.
   e. If it is best for me, the provider may change the plan if they find other issues or problems during the procedure.
   f. If I have a "do not resuscitate" (DNR) request, this will be discussed prior to the procedure.
   g. Students and others may watch the procedure. This must be approved by this facility.
   h. Pictures or video may be taken. They may be used for medical reasons only.
   i. Tissues or items removed from my body may be tested. They will be disposed of properly.

Patient/Guardian Signature (Relationship)	Date	Time
Healthcare Witness signature	Date	Time
Healthcare Witness signature for phone consent	Date	Time