INFORMED CONSENT FORM OR PROCEDURES

Patient Name: _____

I authorize Dr.(s): The providers of Mid-Kansas Wound Specialists to do (Medical term):

My Practitioner has discussed the nature of and reasons for the treatment or procedure with me/my surrogate decision maker. He or she has discussed the usual risks, expected benefits, and possible discomforts, including any problems related to recuperation.

RISKS- I know about the following conditions which may occur with respect to my treatment or procedure.

1.Surgical or other invasive procedure: The usual risks and hazards including Infection, bleeding which may require blood transfusion, nerve injury, additional surgery, blood clots, heart attack, allergic reactions, and pneumonia. Any additional significant risk, complications or side effects of my treatment or procedures have been discussed by my practitioner. These risks can be serous and could extend my hospital stay and or possibly fatal.

2.Fluoroscopy: During your procedure, fluoroscopy may be utilized, Fluoroscopy is a medical imaging technique that provides the practitioners the ability to view a continuous X-ray image. The risks may include but are not limited to continuous injury (skin changes related to radiation exposure) and hair loss.

3.Cardiovascular Surgery only: Your planned procedure may require the use of a heater-cooler device which carries a small risk of infection.

4.Unforeseen Condition: If an unforeseen condition arises during the course of the procedure,
I authorize the practitioner to use his/her best clinical judgement to perform any necessary treatment.

ALTERNATIVES – I understand the other methods of treatment, risks, benefits and possible side effects of these alternatives. This includes the risk and expected results of not having this or any other treatment or procedure. The treatment or procedure indicated on this form is the one I have chosen.

VISITOR AND PHOTOGRAPHY -I understand that students or medical sales representatives may be present to observe my treatment or procedure. I also understand that my treatment or procedure may be photographed or videoed for purposes of documentation.

SEDATION/ANESTHESIA – Risks and benefits of anesthesia are discussed and documented on the pre-anesthesia assessment record.

PATIENT'S CONSENT – DO NOT SIGN UNLESS YOU HAVE READ AND UNDERSTAND THIS FORM.

I have read, or it has been explained to me, and fully understand this informed consent form. And understand I should not sign if all my questions have not been explained to my satisfaction or if I do not understand any of the terms or words contained in this informed consent form. I understand the risks and give my consent for this treatment or procedure.

Patients Signature/Surrogate Relationship to patient Date

Witness to signature Date

Practitioner Signature Date