CONSENT FOR OPERATION OR PROCEDURE

Strabismus Surgery

Monitored Telephone Consent recorded electronically via Epic
Dotted lines to be completed by patient or representative as applicable.

•This completed form must be scanned in Epic•

DATE

HOSP.#

NAME

BIRTH DATE

IF NO PATIENT LABEL, PLEASE PRINT DATE, HOSP. #, AND NAME

1. I authorize Drack, Dumitrescu, Kemp, Larson, Olson, to perform the procedure described below
(Attending Physician[s]/Dentist[s], PA[s], ARNP[s])

upon the patient, as named above. The University of Iowa Hospitals & Clinics is a teaching institution dedicated to the training of the next generation of health care providers. Various members of the health care team will be involved in the procedure and certain portions might be performed by trainees. I understand that the attending health care provider may select Residents, Fellows, and other appropriately licensed and privileged medical personnel to perform parts of the procedure and/or administer anesthesia, and they will perform only those tasks within their scope of practice. The attending health care provider will be present and participate in the critical or key portions of the procedure. The provider(s) obtaining consent: _____

Procedure (no abbreviations and include body part and/or laterality as applicable): **Strabismus Surgery of Eye** (eye muscle surgery)

Right ( ) Left ( ) Bilateral ( )

2. The nature of the patient's condition, the nature and purpose of the procedure, anticipated benefits, possible alternative methods of treatment, known risks involved in either the procedure or of not having the procedure, if any, and possible consequences and complications have been explained.

Risks: Need for additional surgery, diplopia, pain, redness, bleeding, infection, lid changes, loss of vision or eye and death.

3. In the event developments indicate that further procedures may be necessary, I authorize the provider(s) performing the procedure to use their own judgment and do as they deem advisable during the procedure for the patient's best interests.
Note any exceptions: _____

4. I agree to the administration of anesthesia/sedation as is necessary for the procedure.

5. Should the patient have an Advance Directive/Do Not Resuscitate (DNR) order, I understand it may be temporarily suspended during this procedure.

6. Blood: ☐ Not Applicable. The nature, purpose and benefits of receiving blood or blood products; the risks/outcome of receiving blood or blood products; the alternatives, including risks of alternatives, and the outcome if no blood or blood products are used have been explained. **Some of the reasons the patient might need a blood product transfusion are:** 1) Major loss of blood from an injury or high blood loss surgery, 2) Not getting enough oxygen to the tissues, 3) To treat bleeding problems, 4) Decreased blood cell production due to medicines, chemotherapy, or other illness. **The risks of getting a blood or blood product transfusion are:** 1) Harm to lungs or kidneys, 2) Getting too much fluid in the body, 3) Very low blood pressure, 4) Reaction to the transfusion, such as rash, fever, or chills, 5) Increased time spent in hospital, 6) Possible death if the wrong blood is given or if the body rejects the blood given, 7) Infections, such as HIV and Hepatitis, which are very rare. **Alternatives to getting a blood product transfusion might be:** 1) Taking medicine that will cause the body to make more blood, 2) Taking medicine that will decrease bleeding, 3) Special methods during surgery that make blood loss as little as possible, 4) Refuse blood transfusion. I agree for the patient to have blood product transfusions during the hospital visit for this procedure. **If I <u>do not</u> agree for the patient to have a blood product transfusion, the patient or person authorized to consent for patient <u>must sign here</u>:** _____

7. Any tissues surgically removed may be disposed by the hospital in accordance with accustomed practice, including use in research studies, **except as noted:** _____.

8. I am aware that the practice of dentistry, medicine, and surgery is not an exact science and understand that no guarantees have been made to anyone concerning the results of this procedure.

Scribe and/or Interpreter: _____ _____ _____
(If applicable, name/comments) (Date) (Time)

I have been allowed to ask questions in a satisfactory manner. My signature below confirms that I agree to this procedure for the patient as named above.

Signature: _____ **Date:** _____
(Patient or person legally authorized to consent for patient)

_____ _____
(Printed name of legally authorized person signing) (Relationship of legally authorized person)

I declare that I have personally witnessed the patient, or the patient's representative, complete and sign this consent form.

_____ _____ _____ _____
(Signature/title of witness) (Printed name of witness) (Date) (Time)

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