CONSENT FORM FOR OPEN HEART SURGERY

DOCTOR(S):____

has(have) discussed my medical problem with me and has (have) explained the following procedure(s) to be undertaken in lay terms completely understandable to me. I understand that my physician/surgeon may designate assistants, associates, residents, interns, technical assistants, and other health care providers as deemed necessary to assist him/her with the procedure(s) listed below.

Procedure(s):____

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1. I have been fully informed of and understand the attendant risks and the possibility of complications and the medically acceptable alternative(s) to the above-described procedure(s), including the option to refuse such procedure(s). These risks or complications may include, but are not limited to: bleeding requiring blood transfusion or return to surgery for repair, nerve damage, heart, liver, kidney or lung complication and/or even in rare cases death. There is also the possibility of one or more complications arising in the post-operative period preventing normal recuperation. These complications include, but are not limited to: long term ventilation, confusion, fluid accumulation of the lungs, pneumonia, cardiac arrhythmias, fever and abnormal laboratory results. Also infection, long term healing and/or scarring of the surgical site incisions may occur and may require further treatment including surgical repair. There are many other complications that can occur and although less common they pose risk and disability to the patient.
2. I consent to the possible insertion of an intra-aortic balloon pump should it become necessary to temporarily support the heart and circulation.
3. I have been told there is a possibility of significant bleeding and I consent to the re-exploration for bleeding or instability should it become necessary.
4. I understand that my physician may discover other or different conditions which may require different procedures than those planned. If any unforeseen condition should arise during the course of the procedure, I do hereby authorize and request that the physician/surgeon and such associates, technical assistants, and other health care providers take whatever steps necessary to perform whatever procedure(s) they deem advisable, which may be in addition to or different from those now planned and have been discussed with me.
5. I have been made fully aware and acknowledge that the practice of medicine and surgery is not an exact science and that no guarantees or assurances have been made to me regarding expected outcomes.
6. I consent to the proposed procedures(s) by the above physician(s) and (their) associates

Use of Blood Products:

I understand the risks and possible need for use of blood products and **I DO / DO NOT (Circle One)** consent to the administration or transfusion of blood or blood products to me during my procedure and/or its related treatment, whenever deemed necessary by those physicians attending to me, with no warranties made in connection with such blood or blood components.

Disposal of Tissue:

I consent to the disposal by hospital authorities of any tissue, parts, organs, or extremities/limbs that may be removed in connection with my procedure(s). Tissues and/or organs, no longer needed for diagnostic purposes, may be used and/or photographed for research and educational purposes at JFK Medical Center, and it's teaching facilities or for publication in an article related to medical research for the purpose of medical education.

Patient Identification/Label

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Photographs/Observers:
I consent to the taking of photographs, videotaping or other recordings in the course of this procedure for the purpose of advancing medical education as may be authorized by my physician(s) and to the admittance of qualified observers to the opening/procedure room as determined by the hospital.

Medical Device:
To comply with the provision of the Safe Medical Act of 1990, I consent to the release of my social security number for tracking purposes if a medical device is implanted.

Contrast Media:
I understand the risks and consent to administration of contrast media (dye) during specific diagnostic procedures whenever deemed necessary by physicians attending to me. I assume all risks in connection with use of contrast media that include, but are not limited to, allergic reaction, nausea, thrombophlebitis, hives, or renal failure. Very rarely, an asthmatic attack, fall in blood presure, or cardiac arrest can occur and medical treatment may be required to correct these conditions. In extremely rare casess, a fatal reaction has occurred.

I have read and understand all of the above, have had an opportunity to ask questions concerning the procedure(s), and my questions have been answered to my satisfaction.

______________________ ______________________ ________ / ________
Signature of Patient | Print Name | Date | Time

______________________ ______________________
Signature of Witness | Print Name

If patient is unable to consent or is a minor, complete the following:

Patient is unable to consent because______________________________

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______________________ ______________________ ________ / ________
Signature of Authorized Representative | Print Name | Date | Time

____
Relationship to Patient

______________________ ______________________ ________ / ________
Witness (Signature &Title) | Print Name | Date | Time

PHYSICIAN'S CERTIFICATION
NAME OF PHYSICIAN/SURGEON: ______________________________
I hereby certify that the patient or one authorized to act on his/her behalf:

1. Has been fully informed by me or my physician associates, in lay terms understandable to the patient, the nature of the procedure(s), the medically acceptable alternative(s) to treatment, including refusal, and the consequences and risks to the patient inherent to or associated with the procedure(s); and the likelihood of the patient achieving his/her goals.
2. Has authorized the performance of the procedure(s).

______________________ ______________________ ________ / ________
Physician's Signature | Print Name | Date | Time

Patient Identification/Label