ACCT NO:
MR NO:
NAME:
DOB: AGE:
TYPE: SEX:

SALINA REGIONAL HEALTH CENTER

CONSENT TO OPERATION, ANESTHETICS, RADIOLOGY INVASIVE PROCEDURES, & BLOOD PRODUCT ADMINISTRATION

AMBCONSENT

PATIENT NAME: _____ **DATE:** 8-4-2025

Part I: INFORMED CONSENT

A) I consent that I will have [insert name of surgery or procedure]: _____

_____

_____

_____

B) I understand the planned surgery or procedure is: (Patient's own words) _____

_____

_____

C) Surgery/Procedure will be performed by: _____

D) Date/Time Informed Consent Discussion with Practitioner took place: _____/_____/_____ _____:_____
Date *Time*

Part 2: ANESTHESIA CONSENT -- I HAVE BEEN INFORMED THAT ONE OR MORE MAY BE USED

It has been explained to me that sometimes anesthesia involves the use of local anesthetics, with or without sedation. This may not succeed completely. Another type may have to be used including general anesthesia.

A) I consent to be given anesthetic medicine, or other medicine.

❑ Anesthesia by Salina Regional Anesthesia. See Attached Anesthesia Content.

❑ **None:** no anesthesia will be used. **(If None, then proceed to Part 3)**

❑ **Local:** numbs one small area of the body. You stay awake and alert.

❑ **Conscious or intravenous (IV) sedation:** uses a mild sedative to relax you and pain medicine to relieve pain. You stay awake but may not remember the procedure afterwards.

Given by or under the direction of _____.

❑ **Deep sedation:** uses sedatives. Decreased level of consciousness. May need suppoprt to maintain airway.

Given by or under the direction of _____.

Part 3: I HAVE TALKED TO MY DOCTOR AND/OR HEALTH CARE TEAM ABOUT:

a. What the procedure is.
b. How it may help me (the benefits).
c. How it might harm me (the most likely and most serious risks).
d. My other choices for treatment. The risks and benefits of those choices.
e. What will likely happen if I say no to the procedure.
f. Recovery time, pain management, and post-procedure restrictions.

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Part 3(continued): I HAVE TALKED TO MY DOCTOR AND/OR HEALTH CARE TEAM ABOUT:

I understand that:

a. I can change my mind. If I do, I must tell my doctor or team before they start.
b. My doctor may have help from others. Help could include opening and closing the wound. Help might also include taking grafts, cutting out tissue, and implanting devices. I have been told who will help, if known.
c. The staff may change during the procedure.
d. The team will double-check who I am. They will ask what I am having done. This is to protect me.

Part 4: I AGREE THAT: (If I ***DO NOT*** agree with a statement, I have crossed it out with a line and initialed)

a. I will ask questions.
b. No one has promised me definite results for the procedure.
c. If it is best for me, my doctor may change my treatment if he/she finds further serious problems during the procedure.
d. Do Not Resuscitate (DNR) or limited code blue order will be stopped during the operation and the recovery period. It will be restarted when I return to the patient care area.
e. Students and others may watch the procedure. This must be approved by this facility.
f. Pictures or video may be taken. They may be used for medical reasons only.
g. Tissues or items removed from my body may be tested. They will be disposed of with respect. Unless I agree, tissues will not be used for research or be sold.

Part 5: BLOOD ADMINISTRATION

I consent to the transfusion of blood or blood products. I have been told I may need blood products during my surgery and/or hospital stay. I understand that there are risks with transfusion of blood products. These risks may include allergic reactions, damage to my own blood, or infections such as hepatitis and HIV. There may be other risks. These risks can be serious and may cause death. I understand the risk and benefits of blood products. I understand that there are other options to transfusions which also carry risks.

❑ **I DO NOT CONSENT** to the transfusion of blood products

Part 6: SIGNATURES

My questions have been answered. I have read and understand that I am giving my consent.

1) _____ _____ _____/_____/_____ _____:_____
Patient /Representative *Printed Name* ***Signature*** *Date* *Time*

_____
Relationship to Patient (if Representative)

2) _____ _____ _____/_____/_____ _____:_____
Practitioner *Printed Name* ***Signature*** *Date* *Time*

❑ Consent completed with use of interpreter from _____
(Name of Interpreter Service)

Interpreter ID: _____