Informed Consent for Operative / Invasive Procedure *CP02.010*

I, the undersigned, consent to the following operation(s) and / or procedure(s); **Intubation and mechanical ventilation**

to be performed by Dr. _____ and his / her associates and assistants, as indicated below, with knowledge that the attending physician will have primary responsibility for my care specific to the stated procedure.

I understand that different or additional procedures that my physician considers emergent and necessary may be required during the course of the operation(s) / procedure(s) described above and I consent to such procedures.

I understand that physicians who are fellows or residents (resident physicians), may also be involved in the procedure(s), including performing one or more significant task. I further understand that if resident physicians are involved:

- They will perform portions of the procedure(s) based on their level of competence;
- It will be decided at the time of the procedure(s) which resident physicians will participate and their manner of participation, taking into account the following factors: 1) my condition, 2) the availability of resident physicians with the necessary competence, and 3) the knowledge of the supervising physician of the resident physicians' skill sets;
- Any resident physicians performing significant tasks will be under the supervision of their supervising physician, though based on the resident physicians' level of competence, the supervising physician may not be physically present in the same room for some or all of the tasks performed by resident physicians.

I have had the opportunity to ask any questions that I have regarding resident physician involvement.

I understand that my procedure may overlap with another procedure that my physician is scheduled to perform. I understand that this means my physician will be present in the operating room during the critical parts of my surgery, but may not be present for my entire procedure. I understand that my physician or another qualified attending physician will be immediately available should the need arise during my procedure. My physician has answered all of my questions about overlapping operations and I give my consent.

I understand that certain significant tasks may be performed by qualified medical practitioners who are not physicians, acting within their scope of practice as permitted by State law and their clinical privileges granted by the hospital.

Dr. _____ has explained to me the nature and purpose of each operation(s) and / or procedure(s) as well as the substantial risks and possible complications involved, the benefits and the medically reasonable alternative methods of treatment.

The **SUBSTANTIAL RISKS** include but are not limited to (add additional risks as indicated):

☑ perforation and / or injury to adjacent blood vessels, nerves and / or organs
☑ bleeding
☑ infection

During placement of the tube a tooth may be damaged or knocked out. Injury may also occur to the nose, mouth, throat, vocal cords, windpipe, or lungs. If the tube stays in place a long time one or both vocal cords may be injured. Some patients experience decreased oxygen levels or heart beat irregularities while the tube is being placed. The endotracheal tube may accidentally be placed into the esophagus (swallowing tube) resulting in air in the stomach and decreased oxygen in the lung. A sick or injured lung could collapse and require placement of a chest tube to remove the air that collects outside the lung. Any tube in the body has a risk of allowing infection to enter the body.

The **POTENTIAL BENEFIT(S)** include but are not limited to: To breathe for the patient when he/she is unable to, to raise the oxygen levels in the blood, to protect the lungs from saliva and vomit, and to provide a way to remove sputum (mucous) from the lungs.

The **MEDICALLY REASONABLE ALTERNATIVE(S)** are: None. If the decision has been made to place an endotracheal tube, the patient is usually critically ill and has failed to respond to other treatment alternatives such as an oxygen mask.

Patient Name: Patient Identification #:

UFHealth SHANDS

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AC0009

If printed electronically, pages 1 & 2 must be stapled.

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- **I understand and consent to UF Health Shands disposing of any tissue, parts or organs that are removed during the operation(s) and / or procedure(s), in accordance with its usual practice.**
- **I understand that the information I have received about risks is not exhaustive and there may be other, more remote risks.**
- **I have had the opportunity to ask questions regarding the proposed procedure(s) and all my questions have been answered to my satisfaction.**
- **I have read or have had read to me, this Operative / Invasive Procedure Informed Consent form.**
- **I have had explained to me, and I understand the potential benefits and drawbacks, potential problems related to recuperation, the likelihood of success, the possible results of non-treatment, and any medically reasonable alternatives.**
- **I have received no guarantees from anyone regarding the results that may be obtained.**
- **I know the relationship, if any, of my physician or other practitioner, to any teaching facility involved in my care.**

CONSENT

I do hereby consent to the above described operation(s) and / or procedure(s).

Patient Signature _____ **Date** _____ **Time** _____

By placing my initials at the end of this sentence, I also consent to having observers present during my procedure, in accordance with my physician's approval and hospital policy. _____
Initials

Patient Printed Name _____

Staff Witness Signature _____ Staff Witness Printed Name _____

SIGNATURES FOR CONSENT WHEN GIVEN BY REPRESENTATIVE OF PATIENT

If patient is unable to consent, complete the following:

☐ Patient is a minor, or

☐ Patient is unable to consent because: _____

Patient's Name _____

Representative's Signature _____ **Date** _____ **Time** _____

By placing my initials at the end of this sentence, I also consent to having observers present during the procedure in accordance with the attending physician's approval and hospital policy. _____
Initials

Representative's Printed Name _____ Relationship to Patient _____

Staff Witness Signature _____ Staff Witness Printed Name _____

SIGNATURE OF PHYSICIAN WHO OBTAINED CONSENT

I certify that the procedure(s) described above, including the substantial risks, benefits, possible complications, anticipated results, alternative treatment options (including non-treatment) and their attendant risks and benefits, the likelihood of success and the possible problems related to recuperation, were explained by me to the patient or his / her legal representative.

Date _____ **Time** _____

☐ Consent obtained by telephone.

☐ Consent obtained with use of interpreter.

Name of interpreter _____

Signature of Physician Who Obtained Consent _____

Physician Identification Number _____

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