AUTHORIZATION FOR AND CONSENT TO ANESTHESIA

Patient Name____Date____________________Time______________________

I consent for myself or (name of patient)____to receive one or more of the following types of anesthesia by Dr.____(or one of his/her associates).

General Anesthesia	Usual Result	Become deeply asleep. Possibly a tube may be placed into the windpipe to assist breathing.
	Usual Technique	Drug injected into the bloodstream, breathed into the lungs or by other routes.
Subdural or Epidural Analgesia/Anesthesia	Usual Result	Temporary reduced or loss of feeling and/or movement to lower part of the body.
	Usual Technique	Drug injected through a needle or catheter placed either directly into the spinal canal or right outside the spinal canal.
Major/Minor Nerve Block or Intravenous Regional Anesthesia	Usual Result	Temporary numbness, loss of feeling and/or movement of a specific limb or area.
	Usual Technique	Drug injected near the nerves at the area of the operation.
Monitored Anesthesia Care	Usual Result	Reduced anxiety and pain, partial or total loss of memory during the procedure.
	Usual Technique	Drug injected into the bloodstream or by other routes.

I understand that anesthesia may cause temporary problems which include, but are not limited to: impaired judgment; impaired coordination; impaired attention span; nausea; vomiting; headaches; sore mouth or throat; hoarseness; muscle aches; bruises or tenderness.

ADDITIONAL CONSENTS:

1. I consent for the anesthesiologist to change the type of anesthesia given, and the technique used to give the anesthesia if the anesthesiologist reasonably believes such change is indicated based on their professional judgment under the circumstances.
2. I understand that during anesthesia, invasive monitoring may be needed such as an arterial line, central venous pressure line, pulmonary artery catheter, or trans-esophageal echocardiography probe that are placed by the anesthesiologist. I understand the type of operation planned and overall medical condition influences the need for such monitors. I understand the use of such monitors has additional risks.

POSSIBLE RISKS AND COMPLICATIONS:

Potential complications or risks include, but are not limited to: injury to teeth, gums, or lips, injury to blood vessels, aspiration, pneumonia, headache, backache, and injection of medicine directly into a blood vessel, persistent weakness, persistent numbness, residual pain, injury to blood vessels, unconsciousness, depressed breathing, awareness under anesthesia, nerve injury due to positioning, and eye injury. Rare severe complications include, but are not limited to: infection, bleeding, drug reactions, blood clots, permanent loss of sensation, permanent loss of limb function, permanent paralysis, stroke, brain damage, heart attack or death.

DO-NOT-RESUSCITATE (DNR) AND/OR ADVANCED DIRECTIVE:

- ☐ There **is not** a "DNR" order or an "Advanced Directive" in effect.
- ☐ There **is** a "DNR" order or an "Advanced Directive" in effect, however, during anesthesia and during the immediate post anesthesia care, there should be:
  - ☐ Full resuscitation measures provided regardless of the cause.
  - ☐ Attempts to resuscitate only if, in the professional judgment of the treating physicians, the adverse results are believed to be temporary and reversible
  - ☐ Full resuscitation measures except: ____

I have read and fully understand this consent form and know I should not sign this form if all items, including all my questions have not been answered or explained to my satisfaction or I do not understand any of the terms or words contained in this form. I have been informed of the benefits of the planned anesthesia, its risks, and the alternatives. I accept the anesthetic risks and complications as described above.

Additional comments: ____

Patient or Nearest Relative Signature	Date/ Time	Relationship to Patient
Witness Signature	Date/ Time	
Physician Signature	Date/ Time	

1/4/13

51512223

Patient Label

AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES

'ATIENT NAME: ______________________ DOB: ______________

CONSENT: Dr. ______________ has informed me of my diagnosis and the potential risks and benefits of the following procedures in treating me: Esophagogastroduodenoscopy with possible biopsy, polypectomy, dilatation, clipping, banding

My physician or surgeon and assistants will perform this procedure. Students and other health care providers may participate in my case under the guidance of my physician, surgeon or anesthesiologist. I am aware that health care manufacturer representatives may be present during my procedure for technology support. Other possible medical or surgical alternatives to this surgery or procedure have been discussed with me by my physician or surgeon.

I UNDERSTAND THE RISKS INCLUDE THOSE WHICH ARE DESCRIBED BELOW IN THIS FORM AS WELL AS OTHERS.

PROCEDURAL RISKS: 1) This authorization is given with the understanding that any operation or procedure involves some risks and hazards. The most common risks include infection, bleeding requiring blood transfusions, nerve injury, blood clots, heart attack, stroke, allergic reactions, pneumonia, and need for more procedures. These risks can be serious and result in death. **2)** Additional risks specific to this procedure: **Perforation, need for further surgery, bleeding, infection, missed lesions, cardiopulmonary depression**

ANESTHESIA/RISKS: 1) I consent to the use of anesthetics as may be considered necessary by the person responsible for these services (anesthesiologist, surgeon or physician). **2) Risks:** This authorization is given with the understanding that administration of anesthesia also involves risks, including injury to teeth, bodily injury or death.

ADDITIONAL PROCEDURE(S): If my physician or surgeon discovers a different, unsuspected condition at the time of my surgery/procedure which relates to my current condition and is an emergency &/or reasonably requires attention related to my condition, I authorize him/her to perform such treatment as necessary.

TISSUE DISPOSAL: Tissues removed during surgery can be disposed of as usual or used for teaching/research, so long as my name is not used with the following exceptions: ______________________ (if no exceptions, write "none").

PHOTOGRAPHS: 1) I understand that photographs may be taken of me or parts of my body before, during or after my procedure. **2)** My physician or surgeon may show these photographs to my family in explaining my procedure. **3)** Such photographs will become a part of my medical record, subject to the same rules as apply to other parts of my medical record. I also authorize the use of such photographs, either in negative or print form, for purposes connected with education and research, provided my name or any positive identification is not used.

PATIENT CONSENT: 1) I understand there is no guarantee that this operation will improve my condition. **2)** I have read and fully understand this consent form and know I should not sign this form if all items, including all my questions, have not been answered or explained to my satisfaction or if I do not understand any of the terms or words contained in this form.

Patient or Nearest Relative Signature	Date	Time	Relationship to Patient
Signature Witness	Date	Time	
Physician Signature	Date	Time	

3/11/14

Tatel EGD

Patient Label

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Is it really a robot? How does it work?

Robotic surgery actually involves the physician guiding the robot. The robot does NOT do anything the physician does not do first. In addition, the surgical system cannot be programmed, nor can it make decisions on its own.

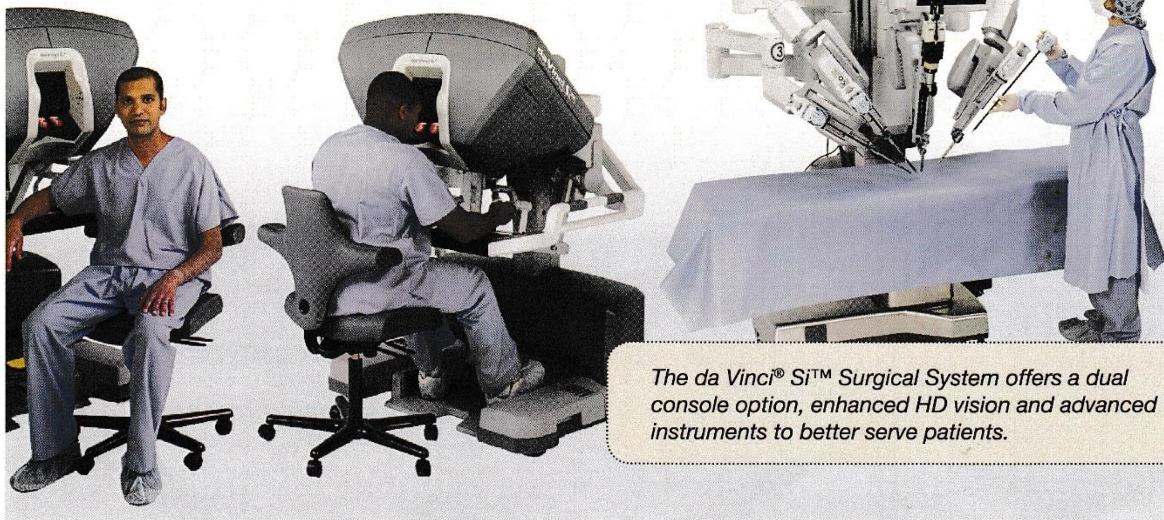
For example, a female patient may undergo a hysterectomy using the da Vinci Si Surgical System at La Porte Hospital. After the physician docks the robot to the patient, the physician sits comfortably at a console a few feet away from the patient on the operating table. Registered nurses and other qualified surgical staff remain by the patient's side during the procedure. The physician operates the robotic arms, using hand and foot controls, without ever actually putting his or her hands on the patient. The robot has four arms: one with a high-powered camera and three with the surgical tools. The physician guides the arms of the robot, which are inserted into the patient's abdomen through small (1/3 to 1/2 inch) incisions.

The highly accurate instruments conduct precise movements with extraordinary control and range of motion. The small robotic arms even filter minute tremors of the human hand to provide extreme steadiness, more precise than a human. The video monitoring system provides a 3D image with 10X magnification of the surgical site for improved visualization.

How will robotic surgery benefit me?

Robotic surgery is an alternative to the traditional "open" surgery. Together, da Vinci couples technology with the skills of your healthcare team to perform complex procedures with four or five small incisions.

Contrary to popular belief, da Vinci surgery may not get you back to your normal routine the next day. While recovery time varies from patient to patient, surgery is still a major medical procedure and requires time to heal properly. However, da Vinci surgery may lessen recovery time from the traditional six weeks to a much more convenient two weeks. This accelerated recovery may ultimately save patients from loss of income as they return to work sooner.



The da Vinci® Si™ Surgical System offers a dual console option, enhanced HD vision and advanced instruments to better serve patients.