



6000

# NORTHSIDE HOSPITAL

English - Spanish

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

**DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS**

PATIENT'S NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**Procedure. Check and initial if additional procedure is to be performed:**

\_\_\_\_\_  STERILIZATION (attach separate, signed consent for sterilization if required - i.e. Medicaid patients)

Initials

CESAREAN DELIVERY

The following has been explained to me in general terms and I understand that:

**\*This consent must be accompanied by a separate signed consent for sterilization when that consent is required.**

The following has been explained to me in general terms and I understand that:

1. The diagnosis requiring this procedure is pregnancy where vaginal delivery is undesired, inappropriate, or there are increased risks to the mother and/or infant.
2. The nature of the procedure is the delivery of an infant by way of an abdominal incision under appropriate anesthesia
3. The purpose of this procedure is to reduce possible increased risks to the mother or infant which might result from vaginal delivery.
4. **MATERIAL RISKS OF THIS PROCEDURE:**  
As a result of this procedure being performed there may be material risks of: INFECTION, ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS OR PARTIAL PARALYSIS, PARAPLEGIA OR QUADRIPLÉGIA, BRAIN DAMAGE, CARDIAC ARREST, OR DEATH.
5. In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to:
  - a. Possible need for immediate surgery or other additional surgery, which might include a hysterectomy (removal of uterus, fallopian tubes and/or ovaries);
  - b. Possible injury to the bowel, bladder, ureter or other pelvic or abdominal structures;
  - c. Possible fistula formation (an opening between bowel, bladder, ureter, vagina and/or skin) caused by an injury to the bowel, bladder or ureter;
  - d. Possible injury to the baby;
  - e. Possible formation of blood clots;
  - f. Possible emboli (clots of blood or other material that might travel to other parts of the body);
  - g. Possible blood loss necessitating transfusion which carries the risk of exposure to AIDS, hepatitis or other infectious diseases;
  - h. Possible injury to the cervix, uterus or fallopian tubes that might require additional surgery or might affect the patient's ability to get pregnant or carry a pregnancy to full term (9 months);
  - i. Possible hernia at the incision site.
6. The likelihood of success of the above procedure has been explained to me.
7. The practical alternative to this procedure is to attempt a vaginal delivery and accept the consequences to the mother and infant.
8. If the patient chooses not to have the above procedure, the prognosis (predicted future medical condition) is possible increased risks to the mother and/or infant, including those set forth in paragraph 4 and 5 and any and all forms of neurological damage to the infant.
9. The likelihood that the patient will require a blood transfusion or administration of blood products has been explained to me.
10. When autologous blood transfusion with cell saver technique (the patient's blood that is lost during the surgery is collected, filtered, and transfused back into the patient in the operating room) is appropriate, there may be further risks to the woman because of the inability to clear fetal blood cells from the filtered blood. These risks include a risk of emboli and possible immunologic reaction of the mother's blood cells against the transfused fetal blood cells, which could pose risk for future pregnancies. Cell saver technique would only be recommended in situations with a significantly elevated risk of hemorrhage (excessive blood loss).

I understand that the physician, medical personnel and other personnel and other assistants will rely on statements about the patient from a variety of sources, the patient's medical history and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the above procedure.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I acknowledge and understand that during the course of the procedures described in paragraph 2 above, conditions may develop which may reasonably necessitate an extension of the original procedures or the performance of procedures which are unforeseen or know known to be needed at the time this consent is obtained. I therefore consent to and authorize the persons described in the last paragraph of this consent to make decisions regarding the performance of and to perform such procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.

I also consent to diagnostic studies, tests, anesthesia, x-ray examination and other treatment or courses of treatment relating to the diagnosis or procedures described herein.

I further consent to retention by the hospital of any tissues, specimens, organs or limbs removed from the patient's body during the proposed procedures to be examined by pathologists to be used for scientific or teaching purposes, and to be disposed on in the discretion of the hospital and its medical staff.

The hospital and the patient's physician have an educational role in the training of medical or paramedical personnel. I consent to such students observing and participating in the patient's care under supervision.

I understand that upon request, Northside Hospital may agree to attempt to obtain a cord blood specimen. However, I understand this service as a courtesy only and I agree that the hospital may not be liable in the event the specimen is not obtained or improperly obtained.

**BY SIGNING THIS FORM I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, AND THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW RELATING TO THE PROCEDURE DESCRIBED HEREIN.**

I voluntarily consent to allow Dr. \_\_\_\_\_ or any physician designated or selected by him or her and all medical personnel under the direct supervision and control of such physician and all personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date \_\_\_\_\_ AM/PM

\_\_\_\_\_  
Relationship to patient if not the patient

\_\_\_\_\_  
Interpreter (if applicable)

\_\_\_\_\_  
Reason Patient unable to sign

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number