McLaren Flint
FLINT, MICHIGAN

CONSENT TO PROCEDURE WITH INTRAVENOUS SEDATION

Date: _____ Time: _____

1. I have been told by my physician, Dr. _____ that my present condition or conditions may effectively be treated by the following procedure(s):

   ☐ **Cardiac Catheterization and Angiography**
   ☐ **Coronary Angiographies, and other Angiographies as may be necessary**
   ☐ **Coronary Angioplasty**
   ☐ **Atherectomy**
   ☐ **Possible Coronary Artery Stent insertion**
   ☐ **Intra-Aortic Balloon Pump Insertion, and Coronary Artery Bypass Surgery, if necessary**
   ☐ **Temporary Pacemaker**
   ☐ **Pulmonary Artery Catheter Insertion**
   ☐ **Arterial Line Insertion**

   I hereby authorize my physician and the associates and assistants selected by him to perform the described procedure(s).

2. I have been told that during the course of the described procedure(s), unforeseen conditions may be discovered that necessitate an extension of the original procedure(s) or different procedure(s) that those described in Paragraph 1. I authorize the above physician, his associates and assistants, to perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted in this Paragraph 2 shall extend to treating all conditions that require treatment and are not known to the physician at the time the original procedure(s) is commenced.

3. I am aware that McLaren Regional Medical Center is a resident teaching facility and that physician residents will be involved with my care under the supervision of my physician. I consent to their involvement and participation in my treatment planning and care.

4. I understand that any medications or drugs I am taking may cause complications with anesthesia or surgery. I understand that it is in my best interest to inform my doctors about all medications or drugs I am taking including, but not limited to herbal and over-the-counter medications, aspirin, cold remedies, narcotics, and street drugs such as PCP, marijuana, and cocaine. I hereby consent to the anesthesia discussed authorizing administration by my physician who is credentialed to provide intravenous sedation services at this health facility.

Intravenous Sedation	Expected Result	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream producing semi-conscious / unconscious state
	Risks	Depressed breathing, injury to blood vessels, recall of events, oversedation, death.

5. I understand that such procedure(s) may involve transfusion of blood or blood cell products. I have been made aware that, despite routine screening procedures, use of blood and blood cell products always carries some risk of transmissible disease, including hepatitis virus, or other blood-borne agents. I have been provided with information regarding alternatives to the administration of blood products. I give authorization to administer to me: ( ) regular blood or blood products from the Blood Bank; ( ) autologous blood only (blood I have given); ( ) designated (directed) donations only; ( ) no blood products. In the absence of a sufficient quantity of blood I have given, I understand regular blood or blood products from the Blood Bank will be used.

6. I authorize McLaren Regional Medical Center to retain, preserve, and use for scientific or teaching purposes or dispose of, at its discretion, any specimen or tissue taken from my body.

7. I acknowledge that full discussion has taken place between my physician and me prior to the procedures(s) herein authorized, that the advantages and disadvantages of such procedures(s), including the risk of infection, have been explained to me, and that alternative methods of treatment have been discussed with me. I have been made aware of certain risk(s) and consequences that are associated with the procedure(s) described in Paragraph 1 and understand that submitting to the procedure(s) may endanger my life or future health.

8. I am aware that the practice of medicine and of surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s).

_____
Signature of Patient

(If patient is unable to sign or is a minor, complete the following: Patient (is a minor_____ years of age) is unable to sign because:

_____

_____ _____
(Witness) (Closest Relative or Legal Guardian)

I, Dr. _____, hereby attest to providing information regarding the patient's risks, including risk of infection, benefits, as well as alternative methods of treatment available to aid the patient and family in the decision process regarding this procedure.

_____ Date/Time_____
Signature of Physician

CONSENT TO PROCEDURE WITH INTRAVENOUS SEDATION

1761- Group 3 (2/12)

820b

PT.

MR.#/RM.

DR.