First Hill
SURGERY CENTER

Laparoscopic Appendectomy Consent Form

Patient Name: _____ Date of Birth:

Guardian Name (if applicable): _____ Patient ID:

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

1 MY PROCEDURE

I hereby give my consent for Dr. _____ to perform a **Laparoscopic Appendectomy** upon me. I understand the procedure is to be performed at the First Hill Surgery Center**.**

I understand that the procedure or treatment can be described as follows:
Utilizing a small camera (laparoscope) inserted into the abdominal cavity my surgeon will view and remove the appendix via multiple small incisions (ports).

This procedure will require anesthesia which will be administered by a qualified anesthesiologist. Your anesthesiologist will be available to discuss this further with you on the day of your procedure.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Partial or complete relief of symptoms of abdominal pain related to appendicitis.

While a appendectomy is often an effective treatment for appendicitis some symptoms may remain after successful surgery, and a possibility exists for the need of future medical or surgical interventions.

3 MY RISKS

I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.

These could include but may not be limited to the following:

- Infection, (possibly requiring medication and/or surgery), bleeding (possibly requiring transfusion), injury to other internal structure, delayed recognition of an injury, possible need for re-operation or other intervention (medical or surgical), possible need to convert to an open operation, possible need for hospitalization (short or long term), delayed recovery, possible change in bowel habits and/or digestion that may require medication (short or long term). Chronic pain, incisional hernia formation, infection, need for re-operation, hospitalization, short or long-term disability or death.

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

4 MY CONSENT

Although most procedures have good results, I understand that **no guarantee**

has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures**.

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required**.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests. These alternative forms of diagnosis and/or treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form.

I have read or had read to me and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed **Laparoscopic Appendectomy** and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

☐ **Patient Signature: _____ Date: _____ Time: _____**

Patient is unable to consent because _____. I therefore consent for the patient.
Authorized Consenter's Signature: _____ Date: _____ Time: _____
Printed Name: _____ Relationship to Patient: _____

Mark this box if telephone consent

Witness Name: _____
PRINT NAME

Witness Signature: _____ Date: _____ Time: _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: _____
PRINT NAME

Physician Signature: _____ Date: _____ Time: _____