
Progressive Surgical Associates

INFORMED CONSENT FOR LAPAROSCOPIC CHOLECYSTECTOMY

It is very important to us that you understand and consent to the treatment your doctor is providing and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended.

Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

Patient's Initials or Authorized Representative

Date

I, _____, hereby authorize Dr. _____ and any associates or assistants the doctor deems appropriate, to perform a laparoscopic cholecystectomy.

The doctor has explained to me the potential benefits of the procedure. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well-being, and safety.

The doctor has explained to me that there are risks and possible undesirable consequences associated with the procedure including, but not limited to, retained gallstones, gallstones that remain in the abdominal cavity or are pushed into the common bile ducts, lung complications, the liver being cut, bleeding, infection, heart complications, blood clots, and death. Injury to adjacent structures such as the common bile duct or small bowel, as well as bile leaking into the abdomen can also occur. I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis, or other diseases. Further, any of these risks or complications may require further surgical intervention during or after the procedure, which I expressly authorize. _____
initial

In permitting my doctor to perform the procedure, I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his/her assistants, or his/her designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.

In the unlikely event that one or more of the above inherent complications may occur, my physician or covering physician will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

The reasonable alternatives to the procedure have been explained to me. These alternatives include but are not limited to, open gallbladder surgery, use of bile acids or lithotripsy. I understand the risks associated with the alternatives include, but are not limited to, continued pain and inflammation of the gallbladder or pancreas.

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I hereby authorize the doctor and/or the hospital or surgical center to utilize or dispose of removed tissues, parts or organs resulting from the procedure authorized above.

I consent to any photographing or videotaping of the procedure that may be performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them.

I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

Signature of Patient
or Authorized Representative

Relationship

_____/_____
Date Time

The Patient/Authorized Representative has read this form or had it read to him/her.

The Patient/Authorized Representative states that he/she understands this information.

The Patient/Authorized Representative has no further questions.

Signature of Witness

_____/_____
Date Time

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, the facts, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the procedure(s).

Physician: _____ Date/Time _____/_____

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USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

_____ Foreign language (specify)

_____ Sign language

_____ Patient is blind, form read to patient

_____ Other (specify) _____

Interpretation provided by _____
(Fill in name of Interpreter and Title or Relationship to Patient)

Signature (Individual Providing Assistance)

Date

Time