Good Samaritan Medical Center
A STEWARD FAMILY HOSPITAL
Steward

CONSENT TO OPERATIVE PROCEDURES

1. I hereby authorize Dr. Vikas Merchia and associates and such assistants as he/she may designate to perform the following operation: ❑ Primary Caesarean Section – elective maternal request
2. I impose no specific limitations or prohibitions regarding treatment other than those that follow (if none, so state): None
3. If any conditions are found at the time of operation that were not recognized before and which call for procedures in addition to those originally planned, I authorize the performance of such procedures.
4. The nature, extent and purpose of the operation, with its associated benefits, potential risks and expected outcomes, as well as the benefits and potential risks of alternative methods of treatment have been explained to me. I acknowledge that no guarantee has been made as to the results that may be obtained.
5. Anesthesia will be given by or under the direction of the Anesthesia Staff.
6. I consent to have the pathologist perform such examination of specimens as may be deemed proper in arriving at the diagnosis. The specimens may also be used to advance medical knowledge or may be discarded.
7. I consent to the televising, videotaping and/or photographing of the operation(s), procedure(s), or treatment(s) to be performed for medical scientific or educational purposes.
8. I consent to the presence of a clinical consultant/observer upon the request/permission of the surgeon.
9. The possible need for a transfusion of blood and/or blood components, the risks involved, (including but not limited to the risk of contracting Viral Hepatitis B, C, or HIV/AIDS, or a major life-threatening transfusion reaction or infection), the benefits, the potential complication, the available alternatives and the possible consequences of not receiving a transfusion have been clearly explained to me. I understand that such risks exist despite the fact that the blood has been tested carefully. Notwithstanding the foregoing, I hereby consent to a transfusion of blood and/or blood components as deemed necessary or advisable by my treating physician during the course of my preoperative, operative and postoperative stay.
   ❑ Patient Refuses ❑ Not Applicable
10. Surgeon's comments, if any:
    RISKS TO MOTHER:
    1) Infection.
    2) Excessive blood loss which may necessitate medication, transfusion, or in rare circumstances, emergency hysterectomy.
    3) Injury to internal organs such as bladder, bowel, nerves, ureter, possibly requiring repair.
    4) Possible vascular and respiratory complications, e.g. blood clots, pneumonia.
    5) Increased risk of complications with future caesarean sections, including placenta accreta.
    6) All surgeries with potential risk of death.

    RISKS TO BABY:
    1) There is the possibility of injury to the baby during the uterine incision or during birth.
    2) The baby may experience difficulty with respiratory function and require special care to help clear secretions and fluids from its lungs.
    3) If the baby is breast fed, the milk will contain small amounts of medications the mother receives.

    SPECIFIC RISKS OF A PRIMARY C/S ON MATERNAL REQUEST:
    1) The risks of placenta previa and accreta increase with each Caesarean delivery, therefore Caesarean delivery on maternal request is strongly discouraged in women who are desirous of several children.
    2) Insufficient evidence is currently available to fully evaluate the benefits and risks of Caesarean delivery on maternal request as compared to planned vaginal delivery.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND THAT THE SURGEON, OR HIS/HER DESIGNEE HAS ANSWERED ALL OF MY QUESTIONS.

I CERTIFY THAT I HAVE CONVEYED THE RISKS AND BENEFITS OF THE PROCEDURE, AS DESCRIBED BY THE PHYSICIAN, TO THE BEST OF MY ABILITY.

Signature of Surgeon/Designee	Date	Time	Signature of Translator	Date	Time
Signature of Patient/Designee	Date	**Time**	Witness	Date	Time