Rose Medical Center

INFORMED CONSENT TO OPERATION OR OTHER PROCEDURE

Restrictive Gastric Band

PATIENT: I **Patient Name authorize : Dr. John S. Weaver** and/or such assistants as may be selected by him/her to perform**:**

Procedure: Laparoscopic Placement of Restrictive Gastric Band and Upper Endoscopy.
This is a placement of a restrictive gastric band to the upper most portion of the stomach. An endoscopy will also be performed to insure proper placement of the band. *(Description in layman's terms of operation or procedure(s) to be performed)*

I understand that the reason for the procedure is: **For Weight Loss**
I acknowledge that no guarantees or assurances have been made to me concerning the results of the operation or procedure(s) and that the procedure may not cure my condition. I have had explained to me alternative methods of treatment and agree to the above surgical approach.

Alternatives include: Continued non-surgical or alternative surgical therapies and treatment

2. I am aware that there are substantial risks and consequences that may be associated with any surgical, medical, diagnostic, or anesthetic procedure. The more common risks and hazards include: infection, bleeding which may require blood transfusion, nerve injury, additional surgery, blood clots, heart attack, allergic reactions, and pneumonia. These risks can be serious, extending hospital stay and possibly fatal. Some significant and substantial risks of this particular procedure include: (THESE ARE NOT PROBABLE RESULTS; THEY ARE STATISTICAL POSSIBILITIES.)
Inadequate weight loss, technical band problems, band slippage, injury to stomach and/or esophagus that may require re-operation or additional medical or surgical treatment.
Anesthetic risks include pulmonary embolism, death, bleeding (possibly requiring transfusion, pneumonia, cardiac events including heart attack, stroke, and subsequent neurological problems, bowel obstruction (early or delayed), intra-abdominal abscess/infection, deep vein thrombosis (blood clots), adhesions bowel/organ/vessel injury, nerve injury. Injury to the liver and/or spleen is possible removal or repair of my spleen may be necessary. A need to convert to an open surgery may be necessary.
Other risk related to the Restrictive Gastric Band placement include peptic ulcer, reflux disease, Incisional hernia, obstruction, stomach/esophageal/bowel perforation or leak, infection, abscess formation, erosion, slippage, internal hernia, and/or need for additional surgery or procedures.
I also accept the possible postoperative problems that may require re-operation to include; need for band removal due to slippage, erosion or infection.
3. I understand and acknowledge that by signing this form I am representing in writing that I have been fully informed to my satisfaction in general terms of the following:

a. Potential benefits and drawbacks to this procedure
b. Potential problems related to my recuperation
c. The likelihood of success
d. The possible results of non-treatment

4. I recognize that, during the course of the operation, additional or different procedures other than those described above may be necessary. I authorize such procedures as are, in my doctor's professional judgment, desirable to my health, including attempts to remedy any conditions that are not known at the time the operation is begun. An upper endoscopy is done during the Restrictive Gastric Band procedure and I accept the risks associated with this including; dental injury, esophagus injury, or perforation (possibly requiring chest tube placement or thoracotomy – opening of the chest for repair/treatment), or injury to the stomach/mouth. throat.

Transfusion of Blood or Blood Products
The doctor has informed me that the possibility of bleeding may occur which would require a transfusion of blood and/or one of its products I understand that transfusions can be done with blood donated by others (homologous), from someone I choose (directed), or if I am the transfusion recipient, my own blood (autologous). I am aware that there are risks associated with transfusions as listed below, and that risks exist in spite of the fact that blood is screened for Hepatitis, AIDS virus, and Syphilis.

Incidence of transfusion risks:	HIV Infection (AIDS Virus)	1:1,930,000	Bacterial Infection	Rare
	Hepatitis B	1:137,000	Severe allergy	Very Rare
	Hepatitis C	1:1,000,000	Mild Allergy	Infrequent
	HTLV-1 Infection	1:641,000	Death	1:1,000,000

****References***: Blood Safety in the New Millennium. American Association of Blood Banks. and Annuals Internal Medicine 2002: Effectiveness of Testing for HIV, Hepatitis C Virus and Hepatitis B Virus in Whole Blood Donations.

I understand the purpose, benefits, and risks of transfusion as they have been described to me by the doctor.
I understand the alternatives to blood transfusion, including what could happen if transfusion is refused.

☐ I consent to transfusion of blood or blood products. ☐ I **do not** consent to transfusion of blood or blood products.
*Patient to initial one of boxes above

6. I consent to the above operation or procedure(s) being witnessed by students or practitioners in the health sciences in connection with their continuing education. I authorize this facility to preserve for scientific or teaching purposes, or to otherwise examine and dispose of, the tissue, organs, the materials or other human remains resulting from the operation or procedure(s) authorized above.

7. I authorize the taking of photographs or movies during a surgical or other procedure and during the subsequent treatment at this facility. I understand that photographs will be used only for purposes of medical study or research, and that the name of the patient will not be used to identify the photographs.
IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OF THE PROPOSED SURGERY OR PROCEDURE (S), OR ANY QUESTIONS CONCERNING THE PROPOSED SURGERY OR PROCEDURE (S), ASK YOUR PHYSICIAN NOW BEFORE SIGNING THE CONSENT FORM.

8. Legal proceedings: I agree that all litigation or arbitration in and relating to the Lap-Band Procedure, including surgery, band fills, infections or any other Lap-Band related complication or problem must be handled in the state of Colorado.

PATIENT'S CONSENT: I have read, or it has been explained to me, and fully understands this Informed Consent form, and understands I should not sign this form if all my questions have not been explained to my satisfaction or if I do not understand any of the terms or words contained in this Informed Consent form.

Date: _____Time: _____(AM/PM) _____ **X** _____
PRINT name ***Patient Signature****/or person with authority to sign for patient*

PHYSICIAN DECLARATION/PHYSICIAN DESIGNEE: I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

Date: _____ Time: _____ (AM/PM) _____ **X** _____
PRINT physician's name ***Physician's Signature***