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PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME &amp; MR#

## CONSENT FOR LAPAROSCOPIC ROBOTIC-ASSISTED PROSTATECTOMY AND ADMINISTRATION OF ANESTHESIA OR SEDATION

### A. CONSENT FOR PROCEDURE

1. I authorize \_\_\_\_\_ to perform the following procedure(s):  
**LAPAROSCOPIC ROBOTIC-ASSISTED PROSTATECTOMY.**

I understand that I may need to perform other urgent procedures that were unanticipated. I consent to the performance of any additional procedures determined during my original procedure to be in my interests and where delay might cause additional harm.

I understand that other qualified practitioners, including residents (doctors who have finished medical school and are getting more training), may be chosen to do or help with procedures. These practitioners may perform significant surgical tasks including: opening and closing incisions, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues. All qualified practitioners will only perform tasks that are within their scopes of practice and for which they have been granted clinical privileges. Residents will only perform all or parts of the procedures under the supervision of my doctor.

2. I understand my diagnosis/condition to be: **PROSTATE CANCER.**
3. I have been told about what results to expect, which includes information about the chances for the expected results and about problems that might occur during recuperation. I know that results cannot be guaranteed.
4. I have been told about and understand the risks and benefits of the procedure(s) listed above. I understand that there are risks for all kinds of surgery. These risks, which can be serious, include bleeding, infection, and damage to nearby tissues, vessels, nerves, or organs. They may result in paralysis, cardiac arrest, brain damage, and/or death. Other risks for this procedure may include: **PAIN, DAMAGE TO RECTUM/BOWEL/URETHRA/BLADDER, BLADDER NECK CONTRACTURE, RESIDUAL CANCER, IMPOTENCE, INFERTILITY, INCONTINENCE, DISCOMFORT OR PAIN AND/OR NUMBNESS OF ARMS, AND DEATH.**

More specifically, these terms can be defined as follows:

- Pain - Post-operative pain is common. It can usually be treated with medications. Some patients may have more pain than others. We will work to manage your pain. You may be referred to the Acute Pain Service if needed. A few patients develop chronic pain conditions. If this happens, you may be referred to the Pain Management Clinic for evaluation and recommendations for further treatment. Your primary care provider may actually be asked to manage your pain medicines with the Pain Clinic if you are referred there.
  - Bleeding - It is possible to have problems with bleeding during or after surgery. Post-operative bleeding may require removal of a hematoma or emergency treatment to stop active bleeding and/or the need for blood transfusion. To reduce risks of bleeding, it is important not to take aspirin or anti-inflammatory medications for 10 days prior to surgery, as directed by my physician. Also, hypertension may cause bleeding.
  - Infection - Should an infection occur, additional treatment including antibiotics may be necessary.
  - Damage to rectum/bowel/urethra/bladder - Tissue, nerves or blood vessels may be damaged during surgery. Injury to surrounding structures may be temporary or permanent.
  - Bladder neck contracture - Surgical manipulation may cause scar tissue to form. The formation of scar tissue may result in bladder blockage requiring medical treatment or surgical intervention.
  - Residual cancer - There is a possibility that there will be residual cancer. Subsequent medical or surgical intervention may be required.
  - Impotence - A weakness or inability to maintain an erection may result.
  - Infertility - Retrograde ejaculation, i.e. a backward flow of ejaculate fluid into the bladder may occur, resulting in infertility.
  - Incontinence - Pads will be required post-operatively for a period of time to catch urine leakage. In rare cases, urinary leakage continues and may be permanent.
  - Discomfort or pain and/or numbness of arms - Arms will be padded and placed at the side of the body during the procedure. In some cases, there is temporary discomfort, pain and/or numbness of the arms post-operatively.
  - Death from anesthesia is very rare but has been reported.
5. I understand the alternatives to the proposed procedure to be: **HORMONE THERAPY, EXTERNAL RADIATION THERAPY, CRYOSURGERY, BRACHYTHERAPY, UNDERGO NO THERAPY, RISKS OF ALTERNATIVE THERAPIES INCLUDE FAILURE TO IMPROVE OR A WORSENING CONDITION. I UNDERSTAND THE RISKS RELATED TO THE ALTERNATIVES.**
6. I understand that for some kinds of medical equipment used during procedures, a representative from the equipment manufacturer may be present, providing consultation or performing checks on the equipment.
7. I understand that photographs and/or video or electronic recordings may occur during my procedure and may be used for internal performance improvement or educational purposes.
8. I understand that any tissues or parts removed during my procedure may be disposed of by the hospital or used for any lawful purpose including education and research.



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**B. CONSENT FOR ANESTHESIA OR SEDATION**

1. When local anesthesia and/or sedation is used by the physician on page one, Section A1:

I consent to the administration of such **local anesthetics** as may be considered necessary by the physician in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures.

I consent to the administration of **sedative medications** by or under the direction of the physician named in Item A1 or the physician in charge of my sedation care. I acknowledge that I have been informed of the nature of the planned sedation and that I understand the risks of sedation to include: allergic reactions to medications, changes in breathing, changes in blood pressure and heart function, nausea and vomiting, aspiration of stomach contents and/or excitement. I understand that recall of the procedure is possible.

2. When regional anesthesia, general anesthesia, or monitored anesthesia care is provided by the personnel in the **Department of Anesthesiology:**

I consent to care provided by the physicians of the Department of Anesthesiology. I acknowledge that the anesthesia may actually be administered by a physician in training (resident) or nurse anesthetist under the direction of the anesthesiologist who is assigned to care for me. The anesthetic technique may be a general anesthetic (“being put to sleep”) and/or a nerve block. I understand that the risks of anesthesia include: sore throat and hoarseness, nausea and vomiting, aspiration of stomach contents, muscle soreness, injury to the eyes, injury to the gums or lips, damage to the teeth or dental work, allergic reactions to medications, recall of procedure, changes in breathing, changes in blood pressure and heart function, nerve injury, cardiac arrest, brain damage, paralysis, or death.

Additional information regarding the various forms of anesthesia and pain control, risks, and options is available from the anesthesiologist directing your care.

**C. PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:**

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE      PRINTED NAME      DATE      TIME

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT, CHECK RELATIONSHIP TO PATIENT:			
<input type="checkbox"/> 1. Agent Named in Advance Directive	<input type="checkbox"/> 4. Adult Child	<input type="checkbox"/> 7. Other Blood Relative	
<input type="checkbox"/> 2. Guardian	<input type="checkbox"/> 5. Parent	<input type="checkbox"/> 8. Other* _____	
<input type="checkbox"/> 3. Husband/Wife	<input type="checkbox"/> 6. Adult Brother/Sister		
FOR MINOR PATIENTS:			
<input type="checkbox"/> 1. Parents	<input type="checkbox"/> 2. Guardian or Legal Custodian	<input type="checkbox"/> 3. Authorized person for child in out-of-home placement	

\* Requires review and appointment by Ethics Consult Service. See Medical Center Policy 024, Informed Consent.

**D. PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:**

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT      PRINTED NAME      PIC #      DATE      TIME

\_\_\_\_\_  
SIGNATURE OF WITNESS (OPTIONAL)      PRINTED NAME      DATE      TIME  
REQUIRED FOR TELEPHONE CONSENTS

**E. INTERPRETER ATTESTATION:**

Interpretation has been provided by:

\_\_\_\_\_  
SIGNATURE OF INTERPRETER/CYRACOM ID #      PRINTED NAME      DATE      TIME