### Disclosure For Surgery or Procedures Requiring Informed Consent

PLEASE READ THIS DOCUMENT CAREFULLY AND ASK ABOUT ANYTHING THAT YOU DO NOT FULLY UNDERSTAND. AFTER YOU HAVE READ IT, PLEASE SIGN ON THE OTHER SIDE IF YOU GIVE CONSENT FOR THE SURGERY OR PROCEDURE.

1. My name is ______________________________. I have talked to my doctor(s) ______________________________ about my condition, which is (symptoms or diagnosis): ______________________________
2. My doctor and I talked about what might happen if we do not treat my condition. We also talked about different ways to treat it. We talked about the advantages and disadvantages of each of these different ways of treating my condition.
3. My doctor wants me to have the following operation(s) or procedure(s):
   ❑ Septal Surgery ❑ Nasal Surgery ❑ Turbinate Surgery
4. My doctor talked to me about how this surgery or treatment might help me. My doctor told me that my treatment might change if there was a change in my condition or they find something different during the treatment. My doctor also told me about how long it would take me to recover.
5. My doctor did not promise that this would cure me or improve my condition. My doctor gave me an opportunity to ask questions about my condition and the different ways to treat it. My doctor answered my questions. I am satisfied with the answers about my treatment.
6. I know there can be risks, complications or side-effects whenever someone has an operation or medical procedure. I know my doctor cannot tell me about every possible risk, complication or side-effect. We did talk about the major ones **(for example: bleeding, infection, pneumonia, heart complications, blood clots, death)** that could happen if I have the operation or procedure. I know what my doctor meant by them.
7. My doctor also told me about these other risks:
   Persistent or severe bleeding possibly requiring transfusions and possibly leading to stroke and/or death, persistent nasal obstruction, bleeding into the eye and/or brain requiring external incisions for drainage, persistent nasal crusting, persistent tearing and/or damage to the tearducts, damage to the nasal septum including hole formation in the septum, numbness and/or chronic pain to the forehead, face, and/or teeth, new or persistent infection with possible spread of infection to form brain infection or abscess, loss of or damage to sense of smell and/or taste, septal hematoma with damage to the appearance of the nose, unfavorable change in external nasal/facial appearance, damage to the eyes including permanent blurred vision and/or blindness, brain damage including damage to the lining of the brain, with brain fluid leak, temporary or permanent scarring of the sinuses, the need for further operations including operations that lead to external scarring, heart attack, stroke, and/or death and other unanticipated risks.
8. My doctor gave me a chance to ask questions about these risks and any other risks I wanted to know about. My doctor answered my questions. I am satisfied with the answers about the risks.
9. My doctor has explained to me that the hospitals of The Ohio State University are teaching institutions and that, in accordance with hospital policies, interns, residents, fellows, physician extenders, and medical students may be doing important tasks related to the surgery or procedure under the direction of my doctor.
10. My doctor talked with me about other treatments, besides the surgery or treatment listed above. We talked about the risks and problems that could happen with those other treatments. I give consent to my doctor(s) and their assistants to do the surgery or treatment listed above.

**Continued on other side – please turn over**

*FS0109*

**THE OHIO STATE UNIVERSITY MEDICAL CENTER**
**&**
**THE ARTHUR G. JAMES CANCER HOSPITAL &**
**RICHARD J. SOLOVE RESEARCH INSTITUTE**

**SEPTAL/NASAL/TURBINATE INFORMED CONSENT**

**Patient Name:**

**Medical Record Number:**

**Date of Birth:**

**NOTE: Doctor must check one (1) box below in paragraph 11. This form is not complete unless 11(a) or one (1) box in 11(b) is checked.**

11. (a) ❑ Use of anesthetic **is not** anticipated in relation to the procedure.

(b) ❑ Use of anesthetic **is** anticipated in relation to the procedure and:

❑ If I am to receive a local anesthetic, with or without sedation, my doctor and I have discussed the general risks of local anesthesia and sedation including: allergic reaction, seizure and depression of breathing.

❑ If a general or regional (spinal, epidural, block, etc.) anesthetic is necessary, a representative from the Department of Anesthesia will discuss the anesthetic with me and obtain a separate consent.

**NOTE: Doctor must check one (1) box below in paragraph 12. This form is not complete unless 12(a) or 12(b) is checked by the doctor. If 12(b) below is checked then 12(b)(1) or 12(b)(2) must be initialed by the patient.**

12. (a) ❑ My doctor told me that the administration of blood or blood products is **not** anticipated related to my treatment.

(b) ❑ My doctor told to me that the administration of blood or blood products **is** anticipated related to my treatment.

*** Initial of Patient or Patient Representative required below if box 12(b) is checked by the doctor.**

(1) _____ I **do** consent to the administration of blood or blood products as my doctor has indicated that one or more of the following blood or blood products may need to be transfused for me before, during or after the procedure: ***packed red blood cells, platelets, plasma, cryoprecipitate and/or granulocytes.*** My doctor explained the benefits of each recommended transfusion to me and told me what she/he hopes it will do for me. My doctor has explained the risks of blood transfusion to me. The risks include, but are not limited to, transfusion reaction and the transmission of infective agents. We also talked about what might happen if we do not treat my condition with a transfusion and about different ways to treat it without needing a transfusion. **This consent will be valid for my entire stay in the hospitals of The Ohio State University. If at any time I decide to cancel my consent for transfusion, I understand that I need to notify my doctor of that decision.**

OR

(2) _____ I **do not** consent to the use of any blood or blood products, my doctor has explained the risks, benefits, and alternatives of a blood transfusion with me and I understand that I will have to complete a separate acknowledgement that I chose **not** to receive any blood or blood products. ( __________ Doctor's Initials)

13. If something unexpected happens or is found during the operation or procedure, that in my doctor's opinion, poses an immediate and substantial risk to my health and needs treatment in addition to or different from what is described in paragraph 3 above, I also agree that my doctor(s) may at that time provide the treatment that is immediately necessary, and may use anesthetic and administer blood and blood products as needed (unless I have chosen **not** to consent to the use of blood or blood products).

PLEASE CROSS OUT AND PUT YOUR INITIALS NEXT TO ANY OF THE BELOW ITEMS FOR WHICH YOU DO NOT GRANT CONSENT.

14. If my doctor agrees, I consent to having staff people in the room from the company that makes or sells the equipment used for my treatment and watch my treatment.

15. I consent to pictures or videos being recorded or televised during my treatment, including appropriate portions of my body, for medical, research or educational purposes, as long as my identity is not shared.

ANY AND ALL MARKINGS ON THIS FORM FOR ITEMS WHICH I HAVE GRANTED CONSENT OR HAVE NOT GRANTED CONSENT HAVE BEEN FULLY DISCUSSED WITH MY DOCTOR. **DO NOT SIGN THIS CONSENT FORM UNLESS YOUR QUESTIONS HAVE BEEN ANSWERED.**

I have read and understand this consent form, or had this form read and explained to me. All the blank spaces have been filled in and the things listed were explained to me. I sign this form as my consent.

| ______________________________ | __________ | __________ |
|---|---|---|
| Signature of Patient | Date | Time |
| Signature of Patient's Representative and Relationship to Patient | Date | Time |
| Signature of Witness (Optional) | Date | Time |

## Physician's Statement

I acknowledge that the nature and purpose of this operation or medical procedure, possible alternative methods of treatment, the anticipated benefits, the risks involved and the possibility of complications or unintended results were explained to the patient or his/her representative by me before the patient consented.

______________________________ Signature of Physician

__________ Date

__________ Time