imprint

☐ Carle Foundation Hospital_____
☐ Carle Physician Group_____
☐ Champaign Surgery Center_____
☐ Danville Surgery Center_____
☐ Carle Hoopeston Regional Health Center_____
☐ Carle Richland Memorial Hospital_____
☐ Carle BroMenn Medical Center_____
☐ Carle Eureka Hospital_____

INFORMED CONSENT FOR OPEN INGUINAL HERNIA REPAIR

CONSENT

PROCEDURE(S)

I authorize _____, and other personnel as he/she may deem necessary to perform the following surgical, medical and/or diagnostic procedures on me for the treatment of my current medical condition, and I voluntarily consent to and authorize these procedures:

Open Inguinal Hernia Repair ☐ Right ☐ Left ☐ Bilateral _____

I realize that surgical, medical and/or diagnostic procedures carry risks which may include infection, bleeding, unacceptable cosmetic results, allergic reactions, cardiac arrest and even death. I also realize that there are risks associated with this particular procedure including, but not limited to: blood clots, urinary retention, injury/perforation to the intestines, bladder or nearby vessels, nerve entrapment, chronic pain, recurrence, and testicular ischemia, any of which may require re-operation or additional treatment or procedures. Additional risks may include: _____

I understand that during the course of the surgical, medical and/or diagnostic procedure my physician may discover other or different conditions that require additional or different procedures than those currently planned. I authorize my physician and other healthcare providers to perform such other procedures which are advisable in their professional judgment. My physician discussed with me whether other well qualified medical practitioners including, but not limited to, residents will perform important tasks of surgery.

BLOOD: I realize that blood or blood products may be given as deemed necessary by my physician for preserving life or health.

DONOR TISSUE/BONE: I understand that certain procedures may require donor bone or tissue implantation.

ANESTHESIA/SEDATION: I understand that the use of medications for the relief of anxiety and pain during surgical, medical or diagnostic procedures may be used. My physician and/or anesthesiologist will discuss with me the benefits and risks of the type of anesthesia / sedation that will be provided.

I understand and acknowledge that Federal and State laws require certain medical conditions/diseases be reported to State and/or Federal agencies. Such conditions include, but are not limited to, HIV, tuberculosis, viral meningitis and sexually transmitted diseases.

UNDERSTANDING AND ACKNOWLEDGMENT

I acknowledge that the following have been discussed with me and that I have an understanding of my current medical condition, the proposed procedure, including risks and benefits, probability of success, alternative treatments and their associated risks, as well as the risks of not having the procedure. I have had the opportunity to ask questions which have been answered to my satisfaction and agree to proceed.

CONSENT FOR TREATMENT

Signature of Patient or Authorized Person	*Date*	*Time*
Signature of Witness	*Date*	*Time*

I have explained the proposed procedure, including risks, benefits and alternatives and reviewed code status with the patient or authorized representative.
☐ CPR ☐ No CPR

Signature of Practitioner	*Practitioner # (or badge #)*	*Date*	*Time*

INTERPRETER SERVICES

I have provided interpretation in _____ *(type of language)* of any verbal and/or written information, including this consent form, that have been provided to the patient/authorized person to consent.

Interpreter Name (print full name)	*Badge #*	*Date*	*Time*

Signature (or if remote source, indicate company used)