



**CONSENT FOR OPERATIVE CARE,
MEDICAL TREATMENT, ANESTHESIA,
PROCEDURAL SEDATION, OR
OTHER PROCEDURE**

Name: _____

Birth date: _____
Valid for 30 days from patient signature date

- Hale Ho'ola Hamakua
- Ka'u Hospital

Date of Procedure: _____

You have the right and obligation to make decisions concerning your healthcare. Your physician can provide you with the necessary information and advice, but because this affects you, you must enter into the decision-making process. This form has been designed to document your decision about treatment recommended by your physician. Please feel free to ask any questions.

• I hereby authorize Dr. **Frederick Nitta** and any associate or assistant involved in my care to treat the following **CONDITION(s)** which has (have) been explained to me.

MEDICAL LANGUAGE: _____

ORDINARY / LAY LANGUAGE: _____

• The **PROCEDURE(s)** planned for my treatment of my condition(s) has (have) been explained to me by my physician as follows:

MEDICAL LANGUAGE: **Induction or augmentation of labor. To give drug Pitocin intravenously to stimulate labor.**

ORDINARY LANGUAGE: **To give drug into the blood system to cause labor to start.**

(Explain the nature of the condition(s) in professional and lay language) At this Facility

• During the course of the operation, postoperative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may require my above named physician and his or her assistants, to perform such surgical or other procedures as are necessary to preserve my life or bodily functions.

• I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.

• No promise or guarantee has been made to me as to result or cure. Any sections below, which do not apply to the proposed treatment, may be crossed out. Both physician and patient must initial all sections crossed out.

• If I need anesthesia my anesthesiologist or nurse anesthetist is responsible to inform me of the plan, risks, benefits and alternatives.

• I consent to the administration of anesthesia (general, spinal, regional, and/or local) or procedural sedation by my attending physician, an anesthesiologist, a nurse anesthetist, or other qualified party (under the direction of a physician) as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney. These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.

• Any tissues or part surgically removed may be disposed of by the hospital or physician in accordance with customary practice.

• I consent to the photographing, video monitoring or other media of the operation or procedure to be performed, including appropriate portions of my body, for the internal purpose of performance improvement, provided that my identity is not revealed by the picture of by descriptive text accompanying them.

• I consent to the observation of the operative procedure for the purpose of advancing medical education.

Any additional comments may be inserted here: **complications include excessive contractions, rupture of uterus, stress to baby; risks, benefits, options discussed. Patient wants to induce.**

BLOOD PRODUCT CONSENT ON REVERSE

FULL DISCLOSURE

I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF:

- a. My diagnosis or probable diagnosis.
- b. The nature of the proposed care, treatment, services, interventions, medications, and procedures.
- c. The potential benefits, risks, or side effects, including problems related to recuperation.

- d. The likelihood of achieving care, treatment, and service goals.
- e. The reasonable alternatives to the proposed care, treatment and services.
- f. The relevant risk, benefits, and side effects related to alternatives.
- g. Any limitations on the confidentiality of information learned from or about me.

 Patient/Legal Representative
 Relationship (if not self): Parent of Minor DPOAH

 Date
 Guardian Surrogate

 Physician
 Other _____

Date

Witness

Date

Time

Place

