DANGEROUS/UNACCEPTABLE ABBREVIATIONS - DO NOT USE

QD QOD U IU MS MSO4 MgSO4 Trailing Zero Lack of leading Zero

*****ALL PRN MEDICATIONS ORDERED MUST HAVE A REASON ******

Date Ordered	Time Ordered	PHYSICIAN'S ORDER

1. Admit date: _____ Surgery date:_____ Pre-admit testing date:_____

2. **ADMIT/PATIENT STATUS ORDER**
   - **a. ADMIT CAMPUS:** ☑ Downtown ☐ Lakeside
   - **b. ADMIT Location:** ❑Med/Surg ❑NICU ❑CCU ❑SICU ❑NeuroICU ❑BMT ❑OBGYN ❑PEDI ❑TATU ❑PCU
   - **c. INDICATE STATUS ORDER WITH A CHECKMARK:**
     - ❑ Admit to inpatient status -> Estimated length of stay _____
     - ❑ Place in outpatient status
     - ❑ Place in Observation status and begin observation services

   Assign to Physician: MD _____ Service: Urology _____

   Diagnosis/Medical Necessity (Description/ICD code required):_____

   _____

   Procedure(s) (Description/CPT code required):_____

   _____

   _____

   _____

   _____

   If this is a combined case LIST SURGEON AND SERVICE LINE HERE: _____

   _____

3. **Drug Allergies:** _____

4. **Height _____cm Weight_____Kg**

5. **Xrays and other tests**
   - ❑ **Chest xray (PA/LAT)** ❑ **EKG** ❑ **Other**_____

6. **Labs**
   - ☑ ***Reminder: For diabetics only:*** Glucose Level, Bedside Frequency: Once on admission
     Comment: goal glucose < 180 mg/dL, if > 180 notify anesthesia
   - ☑ **MRSA and MSSA screening per protocol in Pre-admission Testing**
   - ❑ **Urine HCG (exceptions are previous hysterectomy or age >50 years with no menses for ≥ 2 years)**
   - ❑ **Type and Screen**
   - ❑ **Type and cross match __ units PRBC ON HOLD for OR (specify number of units)**
   - ❑ **Type __ Units FFP ON HOLD for OR (specify number of units)**
   - ❑ **__ Apheresis Platelets (equivalent to 5-6 pack of random donor platelets) ON HOLD for OR**

Physician's Signature	Date & Time	Nurse's Signature	Date & Time
Physician's Printed Name		Nurse's Print Name	Date & Time

DO NOT USE FORM AFTER THE ORDERS HAVE BEEN SIGNED AND FAXED/SCANNED

TULANE HEALTH SYSTEMS

ESR Preopeartive Order Set

Affix Patient ID Label Here

Patient Name: _____

M.R.# _____

DANGEROUS/UNACCEPTABLE ABBREVIATIONS - DO NOT USE

QD QOD U IU MS MSO4 MgSO4 Trailing Zero Lack of leading Zero

*****ALL PRN MEDICATIONS ORDERED MUST HAVE A REASON ******

Date Ordered	Time Ordered	PHYSICIAN'S ORDER

6. Labs (continued)

❑ CBC with platelets/Diff	❑ CRP	❑ Free T3	❑ Testosterone
❑ Basic metabolic panel	❑ Transferrin	❑ Free T4	❑ B-HCG Quant
❑ Comprehensive metabolic panel	❑ PTH	❑ Serum T3	❑ Urine toxicology
❑ Liver function profile	❑ PTH-rp	❑ Serum T4	❑ UA/reflex culture **(choose**
❑ PT/INR	❑ Vitamin D 25 Hydroxy	❑ Prealbumin	**indication)**
❑ PTT	❑ Calcitonin	❑ HgbA1c	❑ Urology patient ❑CVA tender
❑ Platelet Function Assay	❑ Calcium	❑ PSA	❑ Dysuria ❑Urinary frequency
❑ Potassium	❑ TSH	❑ AFP	❑ Suprapubic pain ❑Fever
❑ Sed rate		❑ CEA	❑ Other_____

❑ **Other** _____

7. Diet:

✔ **ESR (Early Surgical Recovery) Patients** NPO After Midnight Except Medications and clear liquids; May have clear liquids up to arrival to the hospital **(Beverages and instructions to dispensed patient in Pre-admission testing unit per protocol)**

Most patients will qualify, exclude patients if high aspiration risk e.g. bowel obstruction or non-functioning GI tract

❑ **NON-ESR (Early Surgical Recovery) Patients** NPO Past MIDNIGHT Except meds only
*** this only includes patients who do not qualify for ESR based on above recommendations***

☑ **All patients:** NPO except meds after arrival to the hospital

8. Vitals per routine (including pulse ox)

9. Nursing Care in Outpatient Surgery:

❑ CHG Bath -> Comments: Cloths for pre-op scrub of surgical site on admission
❑ Hair removal -> Comments: Clip hair in area of surgical site in Outpatient Surgery room

10. IV fluids

☑ **Lactated ringers solution 1000ml IV ON CALL**

11. VTE Prophylaxis:

☑ Apply Sequential Compression Device
☑ **Administer in Outpatient Surgery** (select based on hospital guidelines)
(Do not administer in patients receiving epidural block, please verify with anesthesiologist)

❑ **HEPARIN** SODIUM PORCINE **5000** UNIT SUBQ ON CALL
❑ **HEPARIN** SODIUM PORCINE **7500** UNIT SUBQ ON CALL (**Consider if BMI ≥40kg/m^2**)
❑ **Enoxaparin 40mg** SUBQ ON CALL
❑ Other (Dispense as written) _____

Physician's Signature	Date & Time	Nurse's Signature	Date & Time
Physician's Printed Name		Nurse's Print Name	Date & Time

DO NOT USE FORM AFTER THE ORDERS HAVE BEEN SIGNED AND FAXED/SCANNED

TULANE HEALTH SYSTEMS

Affix Patient ID Label Here

ESR Preoperative Order Set

Patient Name: _____

M.R.# _____

DANGEROUS/UNACCEPTABLE ABBREVIATIONS - DO NOT USE

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*****ALL PRN MEDICATIONS ORDERED MUST HAVE A REASON ******

Date Ordered	Time Ordered	PHYSICIAN'S ORDER

12. Outpatient Surgery Medications

- ☑ **Administer oral medications with small sip of water in Outpatient Surgery**
- ☑ **If the patient cannot tolerate pills by mouth: convert PO meds to liquid version if available**
- ❑ **Scopolamine** Transdermal patch 1.5mg (apply behind ear in Outpatient Surgery prior to surgery) ***(Contraindicated in patients with narrow angle glaucoma, elevated intraocular pressure, & age >65 years)***
- ❑ **Acetaminophen** 1000mg PO x1 ON CALL (consider reduced or avoided dose with liver failure)
- ❑ **Gabapentin** 600mg PO x1 ON CALL (For patients <60 years old/ serum Cr <1.5 mg/dl)
- ❑ **Gabapentin** 300mg PO x1 ON CALL (For patients ≥60 & <70 years old / serum Cr ≥1.5 mg/dl)
- ❑ **Gabapentin** 100mg PO X1 ON CALL (Consider in patients ≥70 years old)
- ❑ **Celecoxib** 400mg PO x1 ON CALL (For patients <60 years old/ serum Cr <1.5 mg/dl)
- ❑ **Celecoxib** 200mg PO x1 ON CALL (For patients ≥60 years old/ serum Cr ≥1.5 mg/dl)
- ❑ **Methylnaltrexone** 12mg SUBQ ON CALL (Decrease dose if patient <60kg and/or Cr≥1.5mg/dl)
- ❑ **Other** (Dispense as written)_____

13. Antibiotic Prophylaxis: (SEND ON CALL TO OR) *Administer antibiotics pre-op x1 dose within 1 hour of incision (except vancomycin, ciprofloxacin, levofloxacin and fluconazole that are given between 60-120 minutes prior to incision)*

******SEE FINAL PAGE OF ORDERSET FOR ANTIBIOTIC GUIDELINES*****

❑ Other antibiotics (Dispense as written)_____

_____

- ❑ Cefazolin 2 grams IV (weight < 120kg) on call
- ❑ Cefazolin 3 grams IV (weight ≥ 120kg) on call
- ❑ Cefoxitin 2 grams IV on call
- ❑ Ampicillin 2 grams IV on call
- ❑ Ampicillin/sulbactam 3 grams IV on call
- ❑ Ampicillin/sulbactam 1.5 grams (weight ≤ 80kg) IV on call
- ❑ Piperacillin/tazobactam 3.375 gram IV on call
- ❑ Fluconazole 400mg IV on call
- ❑ Aztreonam 2 gram IV on call
- ❑ Ciprofloxacin 400mg IV on call
- ❑ Clindamycin 900mg IV on call
- ❑ Gentamycin 5mg/kg IV on call
- ❑ Gentamycin 80mg IV on call
- ❑ Levofloxacin 500mg IV on call
- ❑ Metronidazole 500mg IV on call
- ❑ Vancomycin 15mg/kg IV on call

☑ Auto consult to pharmacy for dosing when IV Vancomycin or IV gentamycin ordered

Physician's Signature	Date & Time	Nurse's Signature	Date & Time
Physician's Printed Name		Nurse's Print Name	Date & Time

DO NOT USE FORM AFTER THE ORDERS HAVE BEEN SIGNED AND FAXED/SCANNED

TULANE HEALTH SYSTEMS

Affix Patient ID Label Here

ESR Preoperative Order Set

Patient Name: _____

M.R.# _____

DANGEROUS/UNACCEPTABLE ABBREVIATIONS - DO NOT USE

QD QOD U IU MS MSO4 MgSO4 Trailing Zero Lack of leading Zero

*****ALL PRN MEDICATIONS ORDERED MUST HAVE A REASON ******

Date Ordered	Time Ordered	PHYSICIAN'S ORDER

14. Regional Block
- ❑ Consult anesthesiology for post-operative pain management (Regional block)

15. Local Anesthetic (on CALL TO OR)
- ❑ Bupivacaine 0.25% vial ON CALL to OR
- ❑ Bupivacaine 0.25% with epinephrine 1:200,00 vial ON CALL to OR
- ❑ Bupivacaine 0.5% vial ON CALL to OR
- ❑ Bupivacaine 0.5% with epinephrine 1:200,00 vial ON CALL to OR
- ❑ **Other** (Dispense as written) _____

16. Miscellaneous orders
- ❑ Belladonna and opium suppository x1 ON CALL to OR
- ❑ _____
- ❑ _____
- ❑ _____

Best person to contact if there are problem with these orders:
NAME: _____ Contact number 504-213-1587

STOP: TO avoids delays make sure the following have occurred

- ❑ **The physician has signed every page**
- ❑ **You included a surgery date**
- ❑ **You included ICD codes**
- ❑ **You included CPT codes**
- ❑ **History and Physical in chart (<30 days before surgery)**

Physician's Signature	Date & Time	Nurse's Signature	Date & Time
Physician's Printed Name		Nurse's Print Name	Date & Time

DO NOT USE FORM AFTER THE ORDERS HAVE BEEN SIGNED AND FAXED/SCANNED

TULANE HEALTH SYSTEM

Affix Patient ID Label Here

ESR Preoperative Order Set

Patient Name: _____

M.R.# _____

PRE-OPERATIVE ANTIBIOTIC REFERENCE --- NO ORDERS ON THIS PAGE

True drug allergy is based on the presence of a patient response with one or more of the following signs/symptoms: respiratory difficulty, hypotension, rash, or hives. In the absence of these findings, an antibiotic of the same classification may be used for surgical prophylaxis.	
Indication	**Pre-op Antimicrobial & Dose**
Abdominal: Esophageal, Bariatrics; Gastroduodenal; Biliary non infected; **Gynecological:** C-section [administer within 60 minutes prior to incision); *before* cord clamping]	Cefazolin 2 g (3g if >120 kg) IV x 1 dose **Allergy**: clindamycin 900mg IV + gentamicin 5 mg/kg IV x 1 dose
Abdominal: appendectomy, biliary infection, colorectal surgery of any type, whipple or small bowel	Colorectal prep: neomycin sulfate 1 g + erythromycin base 1g PO at 19, 18, & 9 hours prior to surgery (**home therapy**) **+** cefoxitin 2 g IV x 1 dose **Allergy**: metronidazole 500 mg IV + gentamicin 5 mg/kg IV x 1 dose
General: any implanted foreign body; hernia repair; PEG tubes; **Head & Neck:** clean procedures; **Plastic Surgery**	Cefazolin 2 g (3 g if >120 kg) IV x 1 dose **Allergy**: clindamycin 900mg IV x 1 dose
Cardiac: coronary artery bypass graft (CABG) +/- valve implant, pacemaker & other implants	Cefazolin 2 g (3g if >120 kg) IV x 1 dose **Allergy**: vancomycin 15 mg/kg IV + gentamicin 5 mg/kg IV x 1 dose MRSA concern: vancomycin 15 mg/kg IV + cefazolin 2 g (3 g if >120 kg) IV x 1 dose **Allergy**: vancomycin 15 mg/kg IV + gentamicin 5 mg/kg IV x 1 dose
Cardiac: pacemaker, defibrillator, ventricular assist device, & other implanted device	Cefazolin 2 g (3g if >120 kg) IV x 1 dose **Allergy**: clindamycin 900mg IV x 1 dose **Allergy**: vancomycin 15 mg/kg IV x 1 dose
Gynecological: all hysterectomy Synthetic pubovaginal sling	cefoxitin 2 g IV x 1 dose **Allergy**: Clindamycin 900 mg IV + gentamicin 5 mg/kg IV x 1 dose
Head & Neck Clean-contaminated procedures (oropharyngeal mucosa is compromised)	Ampicillin/sulbactam 3g (1.5g if less than 80kg) IV x 1 dose **Allergy**: clindamycin 900 mg IV x 1
Neurosurgery: craniotomy, shunts, laminectomies, & spinal fusion; **Thoracic**: non-cardiac	Cefazolin 2 g (3 g if >120 kg) IV x 1 dose **Allergy**: vancomycin 15 mg/kg IV x 1 dose
Orthopedic: internal fixation of fracture & joint replacement (hip or knee), any implanted foreign body	Cefazolin 2 g (3 g if >120 kg) IV x 1 dose **Allergy**/MRSA concern: vancomycin 15mg/kg IV x 1 dose **complete infusion before tourniquet inflation** Gentamicin 5mg/kg IV x 1 dose (if gram negative concern)
Urologic: TURP only, otherwise ***indicated only for patients with known bacteriuria***	Cefazolin 2g (3 g if >120 kg) IV x 1 dose **If catheter in place**: Ampicillin 2 grams IV q6h + Gentamicin 5 mg/kg IV once **Allergy**: clindamycin 900mg IV x 1 dose + gentamicin 5mg/kg IV x 1 dose
Urologic: transrectal biopsy	Gentamicin 80mg IV + Ciprofloxacin 400mg IV x1 cefoxitin 2g IV once
Urologic: Open/lap; cystoscopy with manipulation or upper tract instrumentation (lithotripsy, ureteroscopy)	Cefazolin 2 g (3 g if >120 kg) IV x 1 dose + gentamicin 5mg/kg IV x 1 dose **Allergy**: clindamycin 900mg IV + gentamicin 5mg/kg IV x 1 dose
Urologic: prosthetics, stents, penile prosthetics	Cefazolin 2 g (3 g if >120 kg) IV x 1 dose + gentamicin 5mg/kg IV x 1 dose **Allergy**: vancomycin 15mg/kg IV + gentamicin 5mg/kg IV x 1 dose
Vascular: amputation, arterial surgery, vascular access devices, implants, repair	Cefazolin 2 g (3 g if >120 kg) IV x 1 dose **Allergy**: vancomycin 15mg/kg IV + gentamicin 5mg/kg IV x 1 dose

Effective 01/01/2016

MEDICARE ORDER FORM

DIAGNOSIS:	SCHEDULED PROCEDURE & DATE:

TWO MIDNIGHTS OR MORE

I expect the patient will require hospital care for TWO MIDNIGHTS OR MORE. (Documentation must be present in the medical record to support the expectation of two or more midnights.)

☐ **ADMIT TO INPATIENT STATUS**

LESS THAN TWO MIDNIGHTS **(Check only one status - either Inpatient or Outpatient)**

I expect the patient will require hospital care for LESS THAN TWO MIDNIGHTS or I am uncertain as to the length of stay.

☐ **PLACE PATIENT IN OUTPATIENT STATUS**

☐ **PLACE PATIENT IN OUTPATIENT STATUS and BEGIN OBSERVATION SERVICES**
(Observation is a defined set of monitoring services that is typically ordered to evaluate a patient's condition for the purpose of determining whether the patient should be admitted as an inpatient or discharged.)

☐ **ADMIT TO INPATIENT STATUS** (Documentation must be present in the medical record to support at least one of the following selections; check all that apply.)

- ☐ Inpatient only procedure defined by CMS' Inpatient Only List
- ☐ Patient is medically unstable and requires immediate medical intervention, as well as frequent monitoring and changes in treatment plan
- ☐ Patient has significant risk factors that increase the probability of an adverse event if not monitored closely for an extended time period
- ☐ Patient requires active clinical monitoring, diagnostic studies, procedures or treatment that cannot be completed safely in an outpatient setting
- ☐ Patient failed to improve following outpatient treatment that necessitates further evaluation and treatment

TO BE VALID, THE ORDER MUST BE SIGNED, DATED AND TIMED BEFORE PATIENT DISCHARGE.

Telephone/Verbal Order per _____ Taken/Read Back by _____ Date/Time: _____
Admitting Physician Name (print) Signature/Credential

Resident Signature: _____ Date/Time: _____

Physician Signature: _____ Date/Time: _____

MEDICARE ORDER FORM S
MOS
01/01/16

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	DOB:

PHYSICIAN:

DATE:_____ **SHORT STAY FORM**

History

Chief Complaint/Admit DX: _____

Present Illness: _____

Significant Findings: _____

Family Medical History: _____ _____

Past Illness:_____

Past Operations: _____

Medications: _____

Allergies: _____

Social History: Alcohol Tobacco Other:
Mental History: Alert Disoriented Drowsy Lethargic Other
Immunization Record: (Pediatric): _____
PHYSICAL EXAMINATION: T _____
P_____ R_____ BP_____
General:_____HEENT:_____Heart: Lungs: Abdomen:_____Neurological:____
Other Body Systems (specific to procedure):_____Impression: _____
Plan: _____

PHYSICIAN'S SIGNATURE: _____ DATE/TIME: _____

DISCHARGE SUMMARY:

Final Diagnosis:_____

Diet:_____Regular_____Soft_____Liquid_____Other: _____

Activities: _____

Condition of Pt on Discharge:_____Ambulatory_____Afebrile_____Voiding_____Vital Signs Stable

Medications:_____

Follow-up: _____

Additional Comments: _____

PHYSICIAN'S SIGNATURE:_____ DATE/TIME:

PHYSICIAN'S Printed Name: _____MD_____

Tulane Medical Center
1415 Tulane Ave.
New Orleans, LA

SHORT STAY FORM

SSS 201011-0172

Patient Consent to Medical Treatment or Surgical Procedure and Acknowledgement of Informed Consent

READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: Your physician has recommended that you consider medical treatment/surgery. Louisiana law requires your physician to tell you (1) the nature of your condition; (2) the general nature of the medical treatment/surgery; (3) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor; (4) reasonable therapeutic alternatives and material risks associated with such alternatives; and (5) risks of no treatment.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. Your physician wants you to be as informed as possible. Please read each page of this form carefully. Ask about anything you do not understand and your physician will be pleased to explain.

1. Patient Name: _____

2. Treatment/Procedure: _____

3. Anesthesia to be used: GENERAL: ☑ OTHER: ☐

4. Description of the treatment/procedure: Treatment of distal ureteral disease

5. Indications for treatment/procedure: R/L utereral stricture

6. Anticipated Benefits of the Treatment/Procedure: Relieve blockage, prevent further decrease in kidney func

7. **Material Risks of Treatment/Procedure:**

All medical or surgical treatment involves risks. Listed here and on the attached pages that relate to your specific treatment/procedure are risks associated with this treatment/procedure , its recuperation, and anesthesia, including the likelihood of the risks, based on the available clinical evidence, as informed by the responsible physician's clinical judgment. Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding these risks.

a) Risks generally associated with any surgical treatment/procedure,including anesthesia are: **death, brain damage, disfi guring scars, quadriplegia (paralysis from neck down), paraplegia (paralysis from the waist down), the loss or loss of function of any organ or limb, infection, bleeding, and pain.**

b) ____Risks listed for your procedure by the Louisiana Medical Disclosure Panel: Infection, Bleeding, Scarring

Pain, damage to nearby structures including blood vessels, nerves; need for further procedures

_____ Risks determined by your physician : Bleeding, infection, injury to adjacent organs, pain, scarring, need for additional procedures

Failure to relieve obstruction, recurrence of obstruction, bleeding, infection, injury to adjacent organs such as (right side): liver, bowels, great vessels; (left side) spleen, pancreas, bowel; possible leakage of urine, possible conversion to open procedure

c) Additional risks (if any) particular to the patient because of a complicating medical condition:__.

8. Treatment alternatives including attendant risks and benefits: _____

Observation, Endopyelotomy (antegrade or retrograde), open procedure, chronic stent placement

Patient Consent to Medical Treatment or Surgical Procedure and Acknowledgement of Informed Consent

READ CAREFULLY BEFORE SIGNING

9. **Risks of no treatment:** Decrease in kidney function, loss of kidney function, pain, infections

10. **Acknowledgment, Authorization, and Consent**

(a) **No Guarantees:** I understand that all information given me, and in particular, all estimates as to risks and benefits of this or alternate procedures are made in my physician's best professional judgment. Complications cannot always be accurately anticipated and therefore, there is and can be no guarantee either expressed or implied, as to the success of the medical treatment or surgical procedure.

(b) **Particular Concerns:** I have had an opportunity to discuss with my physician those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

(c) **Questions:** I have had an opportunity to ask my physician, and I have asked, any questions I may have about the information in this Consent Form and other questions I have about the proposed treatment or procedure and all such questions were answered satisfactorily.

(d) **Authorized physician:** Physician (or physician group) responsible for treatment, procedure or therapy described in Item #2, is:

Printed Name: MD

(e) **Who will administer Anesthesia:** Tulane Anesthesia

(f) Physicians other than the Authorized Physician (including but not limited to residents) ◉ **will** ○ **will not**

be performing important tasks related to the surgery, under the supervision of the authorized physician, in accordance with the hospital's policies and the practitioner(s)' or resident(s)' availability and competence level. Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines. I am aware that the authorized physician may not be physically present in the same operating room for some or all of the surgical tasks performed by the resident(s).

(g) **PHYSICIAN CERTIFICATION:** I hereby certify, to the best of my knowledge and ability, I have provided and explained the information contained in this Consent Form, including any attachments, and answered all questions of the patient or the patient's representative concerning the medical treatment, therapy or surgical procedure to be performed.

Signature of Physician: _____ **Date:** _____ **Time:**

Printed Name of Physician: MD

PATIENT'S CONSENT: I, the patient or the patient's representative, hereby authorize and direct the designated physician, together with associates, assistants, residents or qualified medical practitioners of my physician's choice, to administer or perform the medical treatment or surgical procedure described in Item #2 of this Consent Form. I also consent to any additional procedures or services as they may deem necessary or reasonable, including the administration of general or regional anesthesia, x-rays or other radiological services, laboratory services, and the disposal of tissue removed during a diagnostic or surgical procedure.

I have read and understand all information set forth in this document, including any attachments, and all blanks were filled in prior to my signing. This authorization for and consent to medical or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask my physician any questions I have about the contemplated medical treatment or surgical procedure described in Item #2 of this Consent Form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Signature of Patient or Person Authorized to Consent	Date	Time	Signature of Witness	Date	Time

Relationship to Patient (if signature is not patient's) Printed Name of Witness

Tulane Medical Center

Patient Consent to Medical Treatment or Surgical Procedure and Acknowledgement of Informed Consent

Transfusion of Blood and Blood Components - page 1 of 3

READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: Your physician has recommended that you consider medical treatment/surgery. Louisiana law requires your physician to tell you (1) the nature of your condition; (2) the general nature of the medical treatment/surgery; (3) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor; (4) reasonable therapeutic alternatives and material risks associated with such alternatives; and (5) risks of no treatment.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. Your physician wants you to be as informed as possible. Please read each page of this form carefully. Ask about anything you do not understand and your physician will be pleased to explain.

1. **Patient Name:** _____

2. **Treatment/Procedure:** Transfusion of Blood and Blood Components

3. **Anesthesia to be used:** **GENERAL**: [✔] _____ **OTHER**: [ ] _____

4. **Description of the treatment/procedure:** Transfusions are given to replace the part of the blood that is missing or low in your body, such as red blood cells, plasma or platelets

5. **Indications for treatment/procedure:** Anemia, blood loss, hypotension, poor systemic oxygenation

6. **Anticipated Benefits of the Treatment/Procedure:** Improvement of Anemia

7. **Material Risks of Treatment/Procedure:**

All medical or surgical treatment involves risks. Listed here and on the attached pages that relate to your specific treatment/procedure are risks associated with this treatment/procedure and anesthesia, including the likelihood of the risks, based on the available clinical evidence, as informed by the responsible physician's clinical judgment. Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding these risks.

a) Risks generally associated with any surgical treatment/procedure,including anesthesia are: **death, brain damage, disfiguring scars, quadriplegia (paralysis from neck down), paraplegia (paralysis from the waist down), the loss or loss of function of any organ or limb, infection, bleeding, and pain.**

b) __X__ Risks listed for your procedure by the Louisiana Medical Disclosure Panel: (1) Fever, (2) Transfusion reaction which may include kidney failure or anemia, (3) Heart failure, (4) Hepatitis, (5) AIDS (acquired immune deficiency syndrome), (6) Other infections.

_____ Risks determined by your physician: _____

c) Additional risks (if any) particular to the patient because of a complicating medical condition: _____

8. **Treatment alternatives including attendant risks and benefits**: IV Fluids such as saline

Patient Consent to Medical Treatment or Surgical Procedure and Acknowledgement of Informed Consent

Transfusion of Blood and Blood Components - page 2 of 3

READ CAREFULLY BEFORE SIGNING

9. **Risks of no treatment:** Anemia

10. **Acknowledgment, Authorization, and Consent**

(a) **No Guarantees:** I understand that all information given me, and in particular, all estimates as to risks and benefits of this or alternate procedures are made in my physician's best professional judgment. Complications cannot always be accurately anticipated and therefore, there is and can be no guarantee either expressed or implied, as to the success of the medical treatment or surgical procedure.

(b) **Particular Concerns:** I have had an opportunity to discuss with my physician those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

(c) **Questions:** I have had an opportunity to ask my physician, and I have asked, any questions I may have about the information in this Consent Form and other questions I have about the proposed treatment or procedure and all such questions were answered satisfactorily.

(d) **Authorized physician:** Physician (or physician group) responsible for treatment, procedure or therapy described in Item #2, is:

Printed Name: MD

(e) **Who will administer Anesthesia:** Tulane Anesthesia

(f) Physicians other than the Authorized Physician (including but not limited to residents) (●) **will** ( ) **will not**

be performing important tasks related to the surgery, under the supervision of the authorized physician, in accordance with the hospital's policies and the practitioner(s)' or resident(s)' availability and competence level. Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines. I am aware that the authorized physician may not be physically present in the same operating room for some or all of the surgical tasks performed by the resident(s).

(g) **PHYSICIAN CERTIFICATION:** I hereby certify, to the best of my knowledge and ability, I have provided and explained the information contained in this Consent Form, including any attachments, and answered all questions of the patient or the patient's representative concerning the medical treatment, therapy or surgical procedure to be performed.

Signature of Physician: _____ **Date:** _____ **Time:** _____

Printed Name of Physician: MD

PATIENT'S CONSENT: I, the patient or the patient's representative, hereby authorize and direct the designated physician, together with associates, assistants, residents or qualified medical practitioners of my physician's choice, to administer or perform the medical treatment or surgical procedure described in Item #2 of this Consent Form. I also consent to any additional procedures or services as they may deem necessary or reasonable, including the administration of general or regional anesthesia, x-rays or other radiological services, laboratory services, and the disposal of tissue removed during a diagnostic or surgical procedure.

I have read and understand all information set forth in this document, including any attachments, and all blanks were filled in prior to my signing. This authorization for and consent to medical or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask my physician any questions I have about the contemplated medical treatment or surgical procedure described in Item #2 of this Consent Form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Signature of Patient or Person Authorized to Consent Date Time	Signature of Witness Date Time
Relationship to Patient (if signature is not patient's)	Printed Name of Witness

Informed Consent- Transfusion of Blood and Blood Components

Patient Instruction sheet- Not part of the medical record

WHAT IS A BLOOD TRANSFUSION

You may need to receive blood in order to stabilize your condition or to save your life. The type of transfusion and amount of blood that is given to you is a decision your physician will make based on your individual needs. Blood transfusions are given to replace the part of the blood that is missing. If you are anemic, your red blood cell level is lower than the level needed to carry adequate oxygen to the cells in your body. The transfusion given to correct anemia contains red blood cells. If you have a low platelet count and are at risk for bleeding, the component given to you is a platelet concentrate. Plasma or Cryoprecipitate are given to manage clotting problems.

WHAT ARE THE SIDE AFFECTS

Most transfusions proceed without incident. Occasionally, problems arise. You may feel a cold sensation, due to the cool temperature of the blood. Sometimes, fever, chills and hives can occur, which are usually not significant. Rarely, more serious problems, such as infection, shortness of breath, back or chest pain, nausea, vomiting, fainting, or confusion may occur. If you have any of these symptoms during or after the transfusion, immediately call your Nurse or Doctor for assistance. If you have bleeding from the infusion site, you or your Nurse should apply firm pressure directly to the area until the blooding stops.

Delayed reactions may occur days to weeks after a transfusion. Any changes in your general health such as unusual tiredness, change in appetite, unplanned weight loss, kidney failure, dark urine, yellowing eyes or skin (jaundice), swollen glands or heavy sweating at night should be immediately reported to your Doctor.