Physician's Surgical Procedure Disclosure and Patients Consent

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical or diagnostic procedure so that you may make the decision whether or not to undergo the procedures after knowing the risks involved and any treatment alternatives available to you. This information is not meant to alarm you; it is an effort to make you better informed so that you may give or withhold your consent to the procedure. If you do not understand any of the information provided, ask your physician to explain it.

1. DIAGNOSIS: I (we) voluntarily request my physician,

[ ] Luis J. Anglo, M.D. [ ] Greg McClelland and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my CONDITION:

PROSTATE CANCER

2. PROCEDURE(S): I (we) understand that the following surgical procedure or procedures are planned for me. I voluntarily consent to and authorize this (these) PROCEDURE(S) for the following purpose(s):

[ ] DA VINCI COMPUTER ASSISTED (ROBOTIC) RADICAL RETROPUBIC PROSTATECTOMY AND REGIONAL PELVIC LYMPH NODES DISSECTION.

[ ] I DA VINCI COMPUTER ASSISTED (ROBOTIC) RADICAL RETROPUBIC PROSTATECTOMY.

3. MATERIAL RISKS: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks related to the performance of the surgical, medical and/or diagnostic procedure planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for bleeding, infection, scarring, risks of anesthesia, blood clots in veins, possible migration of blood clots to the lungs, risks of blood transfusions, heart attack, stroke, allergic reactions and even death. I (we) also realize that the following additional RISKS may occur in connection with this (these) procedure(s):

- IMPOTENCE (INABILITY TO MAINTAIN AN ERECTION)
- INCONTINENCE (INABILITY TO MAINTAIN URINARY CONTROL)
- STRICTURES OF BLADDER &/OR URETHRA REQUIRING STRETCHING OR FURTHER PROCEDURES
- DAMAGE TO RECTAL WALL (POSSIBLY REQUIRING TEMPORARY COLOSTOMY)
- DAMAGE TO SMALL OR LARGE BOWEL (POSSIBLY REQUIRING OTHER PROCEDURES)
- NO GUARANTEE OF CANCER CURE - NEED FOR FURTHER CANCER TREATMENT SUCH AS RADIATION, HORMONE THERAPY, OR CHEMOTHERAPY
- INFECTION OF INCISION OR ELSEWHERE REQUIRING FURTHER TREATMENT
- EMBOLI (BLOOD CLOTS) FROM VEINS INTO THE LUNG (RARE) (SERIOUS)
- HERNIA FORMATION IN INCISION(S) POSSIBLY REQUIRING FURTHER SURGERY TO REPAIR
- PENILE LENGTH SHORTENING
- IF ONE HAS PRE-EXISTENT VOIDING SYMPTOMS SUCH AS FREQUENCY, URGENCY, GETTING UP AT NIGHT, THEY COULD BE WORSENED AFTER SURGERY. ALSO, INCONTINENCE MAY TAKE LONGER TO RESOLVE OR YOU MAY HAVE AN INCREASED RISK OF PERSISTENT INCONTINENCE.
- RISKS OF PROLONGED ANESTHESIA ESPECIALLY WITH DAVINCI RADICAL PROSTATECTOMY WHICH INCLUDE BUT ARE NOT LIMITED TO TEMPORARY/PERMANENT NEUROPATHY OF THE ARMS AND LEGS, POSTOPERATIVE BREATHING DIFFICULTIES REQUIRING PROLONGED INTUBATION OR INTENSIVE CARE UNIT MONITORING, ETC.
- PARTICULAR TO LAPAROSCOPIC PROCEDURES, THERE ARE RISKS OF CO2 EMBOLISM, TROCAR

INSERTION INJURIES WHICH MAY REQUIRE INTERVENTIONAL PROCEDURES AS WELL AS THE POTENTIAL NEED FOR CONVERSION TO AN OPEN OPERATION FOR VARIOUS REASONS SUCH AS FAILURE TO PROGRESS, ORGAN INJURY REQUIRING REPAIR, ETC.

4. ALTERNATIVES TO PROCEDURE: The following feasible alternatives to this procedure have been discussed with me:

RADIATION THERAPY, RADIOACTIVE IMPLANT, REMOVAL OF ALL MALE HORMONES, ACTIVE SURVEILLANCE/OBSERVATION (NO IMMEDIATE TREATMENT), DIFFERENT SURGICAL APPROACHES, CRYOSURIGCAL ABLATION, HIGH INTENSITY FOCUSED ULTRASOUND (HIFU).

5. ANESTHESIA: I (we) understand that anesthesia involves additional risks but I (we) request the use of an anesthetic for the relief and protection from pain during the planned and additional procedure(s), if any. I (we) realize the anesthesia may have to be changed without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetic, including respiratory problems, drug reaction, paralysis, brain damage, or even death. Other risks and hazards which may result for the use of general anesthetics range from minor discomfort or injury to the vocal cords, teeth or eyes. I (we) understand other risks and hazards resulting from spinal or epidural anesthetics include headaches and chronic pain.

6. TREATMENT LIMITATIONS: I impose no specific limitations or prohibitions regarding treatment other than those that follow: [If none, so state.]

_____
_____
_____

7. DISPOSAL OF TISSUE: I (we) authorize the disposal of any surgically removed tissue or parts resulting from the procedure according to accustomed practice.

8. BLOOD PRODUCTS:

[ ] I (we), consent to the use/administration/transfusion of blood products as deemed necessary.

[ ] I (we), do not consent to the use/administration/transfusion of blood products as deemed necessary.

9. CONSENT TO TREATMENT OF UNFORESEEN CONDITIONS: I (we) understand that my physician may encounter or discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and associated technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

10. OUTCOME: I (we) understand that the practice of medicine is not an exact science, and that no warranty or guarantee has been made to me as to result or cure.

11. CONSENT TO TRAINING PARTICIPATION: This facility may have an educational role in the training of paramedical personnel.

Admittance of students and/or technical representatives

[ ] I (we) consent to the admittance of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

[ ] I (we) do not consent to the admittance of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

CONSENT:

I (we) have been given sufficient opportunity to ask questions about my condition, alternative treatments, risks of treatment, the procedures to be used, and the risks and hazards involved. All of my questions have been answered to my satisfaction, and I (we) have sufficient information to give this informed consent. I hereby consent to the above-described procedure.

I (we) certify that this form has been fully explained to me (us), and that I have read it, or have had it read to me (us), that the blank spaces have been filled in and that I (we) understand its contents.

_____ Date:_____

Patient or Legally Responsible Person Time:_____ (A.M./P.M.)

_____

Signature of Witness (Include Position / Title)

_____

Printed Name of Witness

_____

To Be Completed By Physician After Patient Consent Completed:

I certify that the procedure(s) described above, including the risks, possible complications, anticipated results, alternative treatment options, including non-treatment, have been explained by me to the patient or his or her legal representative before the patient or his/her legal representative consented.

_____

Treating Physician

Date:_____

Time: _____ (A.M./P.M.)