1. **OPERATION or PROCEDURE:** I hereby authorize and consent to the performance of the following operation or procedure (specify site and side of procedure):

   Arthrocentesis (joint aspiration)

   __________________________________________________________________________

   under the direction of Dr. _____________________________________________ or designee with the assistance and participation of fellows, residents, physician extenders, and/or students under the supervision of attending physicians/doctors.

2. **BENEFITS:**

   I understand the reason for and benefits of the operation or procedure are:

   Able to obtain fluid for analysis in order to diagnose cause of symptoms, pain relief

______________________________________________________________________________

3. **RISKS:**

   This authorization is given with the understanding that any operation or procedure involves some risks and hazards. The more common risks of some operations/procedures include infection, bleeding, scarring, nerve injury, blood clots, injury to other organs or blood vessels, allergic reactions, drug reactions, and heart attack. Other procedure have their own risks which can also be serious and possibly fatal. Other risks specific to me for the operation/procedure above include, but are not limited to the following:

   Pain associated with procedure, infection, arterial or venous puncture, nerve damage or joint surface damage

   Risks of not having operation/procedure: Inability to obtain a definitive diagnosis

______________________________________________________________________________

4. **ALTERNATIVES:**

   Alternative forms of care or treatment (if any) include:

   Empiric treatment without definitive diagnosis, no treatment

______________________________________________________________________________

5. **PERSONNEL:**

   I understand that I have been orally advised that I will be cared for and treated by fellows, residents, physician extenders and/or students under the supervision of attending physicians/doctors. Some of the attending physicians and personnel caring for me, such as anesthesiologists, are not employees of the Hospital, and the Hospital has no responsibility for such persons’ actions.

______________________________________________________________________________

6. **BLOOD TRANSFUSIONS:**

   I understand that blood transfusions are sometimes necessary during surgery or as otherwise recommended for patient care. The risks, benefits and alternatives of transfusions have been explained to me, and I consent to receive blood if deemed necessary by my physician.

______________________________________________________________________________

7. **ANESTHESIA:**

   I understand that for this procedure, the act of delivering analgesia/anesthesia has benefits of relief and protection from pain, but carries no guarantees. Common side effects include nausea and vomiting, headache, sore throat or hoarseness and soft tissue swelling.

   Many types of risks and complications associated with anesthesia include, but are not limited to: dreams or recall of intraoperative events, incomplete analgesia, damage to the mouth, teeth or vocal cords, pneumonia, loss of sensation, loss of limb function, paralysis, damage to veins or arteries, adverse drug reaction and in rare instances, permanent brain damage, abnormal heart beats, heart attack, stroke or death.

   I understand that if I am taking medications, they may cause complications with anesthesia or surgery. I understand that it is in my best interest to inform my doctors about the nature of any medications that I am taking including but not limited to aspirin, herbal medicines, cold remedies, narcotics, PCP, marijuana, and cocaine.
CONSENT FOR SURGERY / DIAGNOSTIC AND OTHER PROCEDURES AND TREATMENT

13. VENDOR(s) in OPERATING ROOM:

Vendor(s) or Vendor’s Representative(s) in the Operating Room: I have been informed that vendor(s) or vendor’s representative(s) may be present in the operating room to provide technical or logistical support to my surgeon(s) and/or the operating room staff and authorize such. At no time will any vendor(s) or vendor’s representative(s) provide any direct patient care to me.

14. PATIENT’S CONSENT:

I certify that I have read and fully understand this consent form, that I understand the reason and purpose of the operation or procedure, its risks, benefits and alternatives, and possible complications as explained to me by:

Physician or Clinical Practitioner (Print Name): ___________________________

I certify that all explanations referred to above were made, and that all blanks and statements requiring insertion or completion were filled in before I signed the consent. I acknowledge and understand that no guarantee or assurance has been made as to the results of the procedure.

SIGNATURE OF PATIENT ___________________________ DATE / TIME __________

I certify that I have witnessed the person whose signature appears on this form signing this Consent for Surgery/Diagnostic and Other Procedures and Treatments.

SIGNATURE OF WITNESS ___________________________ DATE / TIME __________

If patient is unable to sign, signature of legally responsible person ___________________________ Relationship to Patient ___________________________

Reason why patient is unable to sign consent: ___________________________

15. PRACTITIONER CERTIFICATION:

The procedure or operation stated on this form, including the possible risks, benefits, complications, alternative treatments (including non-treatment) and anticipated results, was explained by me to the patient or his/her representative.

SIGNATURE OF PHYSICIAN OR CLINICAL PRACTITIONER ___________________________ DATE / TIME __________

16. VERBAL INFORMED CONSENT by TELEPHONE:

NAME OF PERSON GIVING TELEPHONE CONSENT ___________________________ DATE / TIME __________

RELATIONSHIP TO PATIENT ___________________________

TELEPHONE AND ADDRESS OF PERSON GIVING TELEPHONE CONSENT: ___________________________

PRINT NAME OF PHYSICIAN OR CLINICAL PRACTITIONER WHO OBTAINED CONSENT ___________________________

SIGNATURE OF PHYSICIAN OR CLINICAL PRACTITIONER WHO OBTAINED CONSENT ___________________________

PRINT NAME OF WITNESS TO TELEPHONE CONSENT ___________________________

SIGNATURE OF WITNESS TO TELEPHONE CONSENT ___________________________

INTERPRETER: (If Required)

PRINTED NAME OF INTERPRETER ___________________________ DATE / TIME __________

SIGNATURE OF INTERPRETER ___________________________