DATE: _____ TIME: _____

I, the undersigned, consent to the following operation(s) and/or procedure(s):

Postplacental Intrauterine device (IUD) insertion

to be performed by Dr. _____ and his/her associates and assistants, with knowledge that the attending physician will have primary responsibility for my care specific to the stated procedure.

I understand that physicians who are residents (resident physicians), may also be involved in the procedure(s), including performing one or more significant surgical tasks. I further understand that if resident physicians are involved:

- They will perform portions of the procedure(s) based on their level of competence;
- It will be decided at the time of the procedure(s) which resident physicians will participate and their manner of participation, taking into account the following factors: 1) my condition, 2) the availability of resident physicians with the necessary competence, and 3) the knowledge of the supervising physician of the residents physicians' skill sets;
- Any resident physicians performing surgical tasks will be under the supervision of the supervising physician, though based on the resident physicians' level of competence, the supervising physician may not be physically present in the same room for some or all of the surgical tasks performed by resident physicians.

I have had the opportunity to ask any questions that I have regarding resident physician involvement.

As listed below, certain significant surgical tasks may be performed by qualified medical practitioners who are not physicians, acting within their scope of practice as permitted by State law and their clinical privileges granted by the hospital.

Practitioner Type (check one): ☐ Advanced Registered Nurse Practitioner ☐ Physician Assistant ☐ Other _____

Significant Surgical Task(s) to be Performed: _____

Dr. _____ has explained to me the nature and purpose of each operation(s) and/or procedure(s), as well as the substantial risks and possible complications involved, the benefits, and the medically reasonable alternative methods of treatment.

The **SUBSTANTIAL RISKS** include but are not limited to (check if applicable and add additional risks as indicated):
☐ Perforation and/or injury to adjacent blood vessels, nerves, and/or organs ☐ Bleeding ☐ Infection

IUD expulsion; failure of IUD resulting in intrauterine or ectopic pregnancy; infection; injury to other organs requiring additional surgery; IUD migration; difficulty removing IUD requiring surgical removal; irregular bleeding/cramping within first 6 months of IUD insertion

The **POTENTIAL BENEFIT(S)** include but are not limited to:

The Liletta IUD provides contraception for 4 years duration.
Menses may become lighter and/or more infrequent with continued IUD use

The **MEDICALLY REASONABLE ALTERNATIVE(S)** options are:

abstinence; condoms; birth control pills; contraceptive patch; vaginal ring; hormonal implant; DepoProvera injection; other progesterone IUDs; non-hormonal Copper T IUD; sterilization with tubal ligation, Essure, or vasectomy

I have indicated below whether or not I consent to additional operations and/or procedures as are considered diagnostically or therapeutically necessary.

☐ **I consent** **OR** ☐ **I do not consent**

to additional operations and/or procedures as are considered diagnostically or therapeutically necessary on the basis of findings during the course of the operation(s) and/or procedure(s) described above and I accept the risks that may be associated with such additional operation(s) and/or procedure(s).

I have indicated below whether observers may be present during my procedure, in accordance with my physician's approval and hospital policy.

☐ **I give** permission to allow observers in the room during my procedure.

☐ **I do not give** permission to allow observers in the room during my procedure.

☐ **PERFUSION SERVICES:**

I acknowledge **I have been advised and understand** that (a) this and other procedures to which I have consented may necessitate the use of perfusion services, whereby standard blood pumps are used to provide circulation or save cells during my surgery; (b) all perfusion services provided to me will be by "perfusionists", healthcare providers who are independent contractors who provide their services under the supervision and direction of University of Florida faculty or community physicians; (c) as independent contractors, these perfusionists are neither employees nor agents of Shands Jacksonville Medical Center; and (d) I may, if I so desire, make my own arrangements for perfusion services, so long as that perfusionist has been approved by Shands Jacksonville Medical Center and is acceptable to the surgeon.

SEDATION ANALGESIA

1. I, the undersigned consent to the following:
   - ☐ Administration of sedation
   - ☐ Non-applicable or per anesthesia consent
   - ☐ Other: _____

I consent to the above sedation to be performed by Dr. _____and associates and assistants of the doctor's choice with knowledge that Dr. _____ will have primary responsibility for my care specific to the stated sedation.

2. Dr. _____ has explained to me the nature, purpose, and possible consequences of sedation, as well as the substantial risks and possible complication(s) involved, the benefits, and the possible alternative methods of treatment.

The **SUBSTANTIAL RISKS** include but are not limited to: Nausea/vomiting; aspiration; disorientation, low blood pressure; prolonged unconsciousness or drowsiness; pain; allergic reaction; vein irritation; irregular or fast heartbeat; pneumonia; problems with breathing; stroke; or death.

The **POTENTIAL BENEFIT(S)** include but are not limited to: The administration of sedation allows you to undergo the procedure with minimal or no discomfort.

The **MEDICALLY REASONABLE ALTERNATIVE(S)** options are:_____

I have indicated below whether or not I consent to additional sedation procedures as are considered therapeutically necessary.

☐ **I consent** **OR** ☐ **I do not consent**

to additional sedation procedures as are considered therapeutically necessary on the basis of findings during the course of the operation(s) and/or procedure(s) described herein, and I accept the risks that may be associated with my decision.

- **I understand and consent to Shands disposing of any tissue, parts, or organs that are removed during the operation(s) and/or procedure(s), in accordance with its usual practice.**
- **I understand that the information I have received about risks is not exhaustive, and there may be other, more remote risks.**
- **I have had the opportunity to ask questions regarding the proposed procedure(s), and all my questions have been answered to my satisfaction.**
- **I have read or have had read to me, this Operative and/or Other Procedure Informed Consent form.**
- **I have had explained to me, and I understand the potential benefits and drawbacks, potential problems related to recuperation, the likelihood of success, the possible results of non-treatment, and any medically reasonable alternatives.**
- **I have received no guarantees from anyone regarding the results that may be obtained.**
- **I know the relationship, if any, of my physician or other practitioner to any teaching facility.**

CONSENT:

I do hereby consent to the above described operation(s) and/or procedure(s)

Patient Signature: _____ Patient Printed Name: _____ _____ _____
Date Time

Witness Signature: _____ Witness Printed Name: _____ _____ _____
Date Time

SIGNATURES FOR CONSENT WHEN GIVEN BY REPRESENTATIVE OF PATIENT:
If patient Is unable to consent, complete the following.

☐ Patient is a minor **OR** ☐ Patient is unable to consent because: _____

Patient's Name: _____ _____ _____
Date Time

Representative's Signature: _____ _____ _____
Date Time

Representative's Printed Name: _____ Relationship to Patient: _____

Witness Signature: _____ Witness Printed Name: _____ _____ _____
Date Time

SIGNATURE OF PHYSICIAN WHO OBTAINED CONSENT:
I certify that the procedure(s) described above, including the substantial risks, benefits, possible complications anticipated results, alternative treatment options (including non-treatment) and their attendant risks and benefits, the likelihood of success and the possible problems related to recuperation, were explained by me to the patient or his/her legal representative.

_____ _____ _____ _____
Signature of Physician Who Obtained Consent Provider # Date Time