17762A

MRN DOB AGE

OOS # ATT MD

**Norwalk Hospital**
**Norwalk, Connecticut 06856**
**Consent for Operation or Other Procedure**

1. I _____ (name of patient) or _____ (person authorized by law to sign on patient's behalf)
hereby authorize Dr. John Garofalo and/or such assistants as may be selected by him/her to treat the condition(s) which appear indicated by the diagnostic studies already carried out, by performing the following procedure(s).
Hysteroscopy and resection of submucous fibroid, Possible laparoscopy

2. If known, list name of assisting surgeon or interventionalist: _____

3. The procedure(s) necessary to treat my condition (has/have) been explained satisfactorily to me as have the risks of, and alternatives to, the procedure(s).

4. It has been explained to me that during the course of the operation, unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in Paragraph 1. I, therefore, authorize and request that the above named physician, his/her assistants and/or such assistants named by him/her to perform such surgical or other invasive procedures as are necessary and desirable in the exercise of the physician's professional judgment. The authority granted under this Paragraph 5 shall extend to treating all conditions that require treatment and are not known to the above physician at the time the operation is commenced. Any tissue removed during this surgical or other invasive procedure may be disposed of by the Hospital. In certain cases, non-medical personnel may be present in the room as technical advisors/observers.

5. I have also been informed that certain complications, including, but not limited to, infection, and/or bleeding may occur. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation(s) or procedure(s).

6. Some of theadditional risks of this procedure are:
Perforation of the uterus, hemorrhage, damage to adjacent organs, fluid overload, failure to remove the fibroid in its entirety, recurrence of fibroids, loss of fertility.

7. I consent to the administration of anesthesia to be administered by or under the direction and supervision of an anesthesiologist in private practice with clinical privileges at Norwalk Hospital. If conscious sedation is administered, I consent to the administration of conscious sedation by the physician performing the procedure. The risks, benefits and alternatives of either method of sedation have been or will be explained to me by the anesthesiologist or by the physician performing the procedure, depending upon the method of sedation used. For those procedures which may require a blood or blood product transfusion, you will be asked to read and sign a separate consent form for blood and/or blood product transfusion. Your physician will discuss the potential need for blood transfusion if appropriate.

_____ M.D. Signature

_____ Signature of Patient

_____ Date _____ Time AM / PM

_____ Signature of Person Authorized by Law to Sign on Behalf of Patient

_____ Relationship to Patient/Reason for Person other than Patient Signing

**Telephone Consent**

_____ M.D. Signature

_____ M.D./R.N./P.A. Witness to Telephone Consent Signature

_____ Date _____ Time AM / PM

_____ Date _____ Time AM / PM

Form 17-762A (10/28/05)