Loyola University Medical Center
Consent for Surgery

1. I hereby authorize Dr. David A. Hatch, attending physician, and such assistants and associates as may be elected by him to perform the following procedure(s) upon: [Patient's Name]

   Procedures: [Laparoscopy (looking through a telescope in the abdomen to find a testicle). Possible orchiopexy (bringing the testicle down into the normal position in the scrotum). Possible orchiectomy (removal of a shrunken testicle). Possible scrotal orchiopexy (anchoring the other testicle to prevent twisting)]
   (Location must be specified: Right, Left, Bilateral, etc.)

2. I understand that this procedure(s) appears to be indicated by the diagnostic studies and/or clinical observations already performed regarding the following condition:

   Condition requiring the procedure(s): [Cryptorchidism (undescended testicle)]

3. I authorize the administration of anesthesia as may, in the exercise of good professional judgment, be necessary or advisable by the physician responsible for administering anesthetics.

4. I authorize the administration of blood and blood products as may be considered necessary or advisable in connection with the procedure(s) described above.

5. The nature, purpose, and possible complications of the procedures and medical services described above, the risks and benefits reasonably to be expected, and the alternative methods of treatment have been explained to be by my physician. I understand the explanation I have received.

   Possible Complications: [Rising of the testicle out of the scrotum (less than 1/100), Infection (very rare), Bleeding (very rare), Injury to the testicle (very rare), others]

6. I recognize that during the operation unexpected conditions may be revealed which require my doctors to perform additional or different procedures than those described above. I hereby authorize and request the physician performing these procedure(s) and his assistants or designees perform such other procedures as are, in the exercise of good professional judgment, necessary and desirable. I understand that these procedures may include surgery as well as other forms of treatment. The authority granted in this paragraph shall extend to remedy all conditions found during the operation that require treatment, and that are not known at the time the procedure is commenced.

7. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure.

8. I consent to the photographing or televising of the procedure to be performed, including appropriate portions of the patient’s body, for medical, scientific, or educational purposes, provided the patient’s identity is not revealed by the pictures or by descriptive texts accompanying them.

9. For the purpose of advancing medical education, I consent to the participation of residents, fellows and medical students in the procedure and to the admittance of observers to the room in which the procedure(s) is performed. These observers may include representatives from medical device manufacturing companies demonstrating or providing technical support for new procedures or equipment.

10. I consent to the disposal by hospital authorities of any tissues or body parts that may be removed.

11. I acknowledge that I have read this document in its entirety and that I fully understand it, that all blank spaces have been completed and that any disagreeable sections have been crossed off, prior to my signing.

12. I understand that I have the right to cancel my surgery at any time, even after I have signed this consent form. I further understand that if I have questions about my proposed surgery, I have the right to have those questions answered before surgery and that I am under no obligation to proceed with the surgery.

Consenting Party:

[ ] Mother
[ ] Father
[ ] Legal Guardian

Date
Time
Print Name
Signature

Witness:

Print Name
Signature
AFFIRMATION OF INFORMED CONSENT BY PHYSICIANS

I affirm that I have informed the above-named patient or the patient’s authorized representative, of the condition requiring surgical treatment and diagnostic procedures referred to above and that I have, consistent with my best medical judgment, fully explained the nature and purposes of all the treatment and procedures consented to in the above consent form, possible alternative methods of treatment and procedures, the risks involved and the possibility of complications in the treatment and procedures consented to and in alternative treatments and procedures, and that, after the foregoing information had been explained, the patient or representative indicated that he/she understood that information and consented to such treatment and/or other procedures described in the above consent form. I also affirm that the patient or patient's authorized representative signed this consent form in my presence. In the event that the patient was not competent to sign this consent form and the patient's authorized representative was not available to sign, I affirm that I obtained consent via telephone.

_________________________  ________________________________
Date                              David A. Hatch, M.D.

INTERPRETER

I affirm that I acted as interpreter for the patient or the patient’s representative and accurately and completely translated into the __________________ language both the statements contained on this form as well as the statements made by the physician, Dr. ________________________, to the patient and/or the patient’s representative and that the patient or the patients representative stated that he or she understood all of the statements and consented to the treatment and/or other procedures described in those statements.

_________________________  ________________________________
Date                              Signature

_________________________  ________________________________
Relationship to Patient            Print Name