M04L
01/04

DUKE UNIVERSITY MEDICAL CENTER

REQUEST AND AUTHORIZATION FORM FOR OPERATIVE OR OTHER PROCEDURE

AA0000
NAME , PATIENT

1. I request and authorize Dr. ______________________ (Attending Physician) and /or his/her associates to perform the following procedure(s)on: PATIENT NAME
(name of patient)

Description of procedure(s): **Transvaginal Oocyte Retrieval** - Placing a needle through the vagina under ultrasound guidance to obtain eggs from the ovaries.

2. I further request the administration of such anesthetics as deemed necessary or desirable. I understand that administration of anesthesia carries risks separate and apart from the risks of the surgical procedure.

3. I further consent to the administration of such drugs, infusions, plasma, blood transfusions, or any other treatment, injection or procedure deemed necessary in the judgment of the attending physicians. The possible need for, risks of, and alternatives, including possible results of non-treatment, to blood transfusion have been explained to me.

4. The attending physician or his/her designee has provided sufficient information to give me a general understanding of the nature and purpose of the operation and/or procedures, the benefits thereof and the usual and most frequent risks and hazards involved. Alternative methods of treatment and the risks and benefits of these alternatives have also been explained to me.

5. It has been explained to me that during the course of the procedure unforeseen conditions may arise which may necessitate surgical or other procedures in addition to or different from those contemplated. I therefore further authorize the above – named physician and/or associates or assistants to perform such additional surgery or other procedures as (s)he or they deem necessary or desirable.

6. I recognize that the results from the practice of medicine and surgery are not absolutely predictable, and I acknowledge that no guarantees or assurance have or can be made concerning the results of such operation(s) or procedures(s).

7. I agree that any tissues, organs and body fluids removed during the course of the operation(s) or procedure(s) may be examined, documented, preserved and/or disposed of in a manner considered proper for purposes of diagnosis, study and advancement of medical knowledge, provided the patient's identity is not revealed.

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DIAGRAMS AND/OR ADDITIONAL NOTES:

Risks including but not limited to:

- Bleeding
- Infection possibly requiring antibiotics
- Damage to nearby structures including uterus, fallopian tubes, bowel, bladder, major nerves and blood vessels (less than 1%).
- Rarely - Possible need for further surgery including laparoscopy (placing camera into abdomen via small incision near the umbilicus) or laparotomy (surgical incision in the abdomen).
- Medical complications
- Complications with anesthesia

I CERTIFY THAT I HAVE READ THIS FORM, OR IT WAS READ TO ME, AND THAT I FULLY UNDERSTAND IT, THAT I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, AND THE ANSWERS AND ADDITIONAL INFORMATION PROVIDED HAVE MET WITH MY SATISFACTION.

____ __________________

Signature of Patient/Next of Kin/Guardian Date

____

Relationship to Patient (if other than patient)

I certify that the patient/next of kin/guardian has answered "yes" to all of the following questions:

a) Did your attending physician or his/her designee explain the procedure to you?
b) Have all of your questions about the procedure been answered?
c) Have you consented to the proposed procedure?
d) Is this your signature on the consent form?

____ M.D. __________________

Witness (Attending physician or designee) Date