Data S2: Adult Tissue Consent Document (Related to STAR Methods)

UCSF Health

UNIT NUMBER

PT NAME

DATE OF BIRTH

AUTHORIZATION FOR SURGERY, SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURE, BLOOD TRANSFUSION AND ADMINISTRATION OF ANESTHETICS (Page 1 of 2)

LOCATION DATE

1. I authorize _____, M.D., and associates to perform the following operation(s) or procedure(s): _____

_____

I understand that UCSF Medical Center is a teaching institution and that associates or assistants involved in the operation(s) or procedure(s) may include residents, fellows, medical students or other allied healthcare professionals. I authorize that such associates or assistants may perform or observe portions of the operation(s) or procedure(s) under the direction of the physician(s) identified in paragraph 1 above. That physician may be out of the operating or procedural room for some of the surgical tasks done by the associates and assistants if the physician(s) identified in paragraph 1 determines it is safe to do so.

2. I authorize the administration of anesthesia and/or sedation as may be considered necessary or advisable. I have been advised that there are certain risks associated with anesthetics that may include allergic reactions, and/or drug intolerances, and dental, mouth or throat damage, discomfort or soreness. I understand that the explanations that I have received may not be exhaustive or all-inclusive and that other more remote risks may be involved.

3. I authorize the use of pathology and radiology services if necessary. I understand that any tissue removed will be disposed of at the discretion of the hospital pathologist or designee. I authorize the pathologist to retain, preserve, use or dispose of any tissues, organs, bones, bodily fluid or medical devices that may be removed during the operation(s) or procedure(s). I understand that such specimens may be used for research, as permitted by federal and state law. I understand that I have no property ownership or interest in such specimens or data derived from these specimens and no right or entitlement in any research or research project using or derived from the specimens.

My tissue:

☐ **may be used in medical research**

☐ **may not be used in medical research**

4. The nature and purpose of the procedure or operation, the likelihood of benefits, risks, complications and side effects of the procedure or operation and its alternatives, possible alternative methods of treatment (including the risks related to not receiving the operation or procedure) and potential problems that might occur during recuperation have been explained to me by Doctor _____. My consent is given with the understanding that any operation or procedure involves risks and hazards some of which can be serious and possibly fatal. I understand that risks may vary depending on the operation or procedure for which I am consenting. I am aware that the practice of medicine and surgery is not an exact science and no guarantee has been made as to the results or cure. I understand that the explanations that I have received may not be exhaustive or all-inclusive and that other more remote risks may be involved.

UCSF Health

AUTHORIZATION FOR SURGERY, SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURE, BLOOD TRANSFUSION AND ADMINISTRATION OF ANESTHETICS (Page 2 of 2)

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

5. Transfusion: (strike out if not applicable); My doctor has discussed with me that there is a reasonable possibility that a transfusion of blood or blood products may be necessary. I have received a copy of the transfusion information form describing my transfusion options (unless I have a life-threatening emergency or medical contraindications). My doctor has discussed the risks, benefits and alternatives of the transfusion of blood and blood products with me. I have also learned about the option of pre-donating my own blood and have had the opportunity to discuss this matter with my doctor.

   The patient ☐ has ☐ has not been given the information form based on medical indications

   ________________________________ (physician signature)

   STOP By signing this consent form:

   ☐ **I DO** ☐ **DO NOT** (check one) consent to the transfusion of blood or blood products, as my doctor may order, in connection with the operation(s) or procedure(s) discussed in this form.

6. I understand that I have the right to refuse any proposed operation or procedure any time before it is performed. During surgery, additional procedures which are in addition to, or different from those set forth in paragraph 1 may be carried out as considered necessary for my well-being by my physician or surgeon for conditions not known at the time the operation or procedure commenced.
7. I understand that there may be a health care industry representative or other visitors present, with the approval of UCSF, during my operation or procedure for purposes of medical observation or to provide technical support.
8. I acknowledge that I have the right to be informed if my physician has any economic interest related to the performance of the operation(s) or procedure(s) beyond compensation for the surgery or procedure performed.
9. In the event of an accidental exposure to my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV, Hepatitis or other bloodborne pathogens.
10. I have had full opportunity to ask questions concerning my condition, the authorized procedure(s) and/or surgery(s), the alternatives, and the risks and consequences associated with it. All the questions I have asked have been answered.

My signature is my acknowledgement that I have read, understood, and agreed to the above, that I have received all the information I desire regarding the operation/procedure, and that I specifically agree to the performance of the operation or procedure.

Date ________ Time ________ M. Patient's Signature ______________________

☐ Patient is a minor and patient's parent / conservator / guardian (circle one) signed.

☐ Patient is incompetent and patient's conservator / guardian (circle one) signed. STOP

☐ Patient is unable to sign because ______________________

Language ☐ English ☐ Other ______________________

☐ Interpreter Used ☐ In person ☐ Telephone

Interpreter Name/Individual ID Number (please print): ______________________