1. I hereby authorize_____and/or such associates or assistants as may be selected by
Print Name of Provider
said provider to perform the following procedure(s) which has (have) been explained to me:

**Insertion of a Cardiac Reshynchronization Biventricular pacemaker (CRT-P) an electrical device which is inserted under the skin of the upper chest to assist the electrical and pumping function of the heart through small wire(s) placed in the heart.**

2. The treatment(s) planned for my condition(s) has (have) been explained to me by my provider. I understand them to be:

3. I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than set forth above. **I therefore authorize my above named provider, and his or her assistants or designees, to perform such surgical or other procedures as are in the exercise of his, her or their professional judgment necessary and desirable.**
4. **I have been informed that there are significant risks** such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may occur from the performance of any procedure. Other risks include the potential hazard of prolonged or frequent radiation exposure to include but not limited to the following, short term and rare side effect: skin irritation, skin ulcers, a small increase in the lifetime risk of cancer, Female (childbearing age) a small potential hazard to fetus. These risks can be serious and possibly fatal. **I acknowledge that no warranty or guarantee has been made to me as to result or cure.**
5. **I consent to the administration of anesthesia by my attending provider, by an anesthesiologist, CRNA or other qualified party under the direction of a provider as may be deemed necessary. I understand that all anesthetics involve risks of complications and serious possible damage to vital organs such as brain, heart,lung, liver and kidney and that in some cases may result in paralysis, cardiac arrest and/or brain death fromboth known and unknown causes.**
6. Any tissues or parts surgically removed may be disposed of by the hospital or provider in accordance with accustomed practice.

**Full/Limited Disclosure**

7. **I recognize that I have the right to have clearly described to me by my provider the following points:**
   - **a)** the nature and character of the proposed treatment;
   - **b)** the anticipated results of the proposed treatment;
   - **c)** the alternative forms of treatment; and complications, side effects, and anticipated benefits involved in the proposed treatment, and in the alternative forms of treatment, including non-treatment.
   - **d)** the recognized serious possible risks,

***(check one)***

- ☐ My provider has informed me of the above points to my satisfaction prior to my authorization of the proposed treatment.
- ☐ I have decided that I do not want to be told of the above points.

8. **USE OF BLOOD DURING THE PROCEDURE**

- ☐ I consent to the transfusion of Blood and Blood Products as deemed necessary.
- ☐ **I DO NOT** consent to a blood transfusion during this procedure. (Refer to the Consent for Non Blood Medical Management).

I certify that this form has been fully explained to me, that I have read it and or have had it read to me, and that I understand its contents.

Patient's Name (printed)

Patient / (Parent if patient is a minor) /Authorized Representative — Date — Time

Relationship if Authorized Representative

Witness to Patient / Legal Guardian Signature — Date — Time

**PROVIDER STATEMENT:**

I confirm that I have explained to the patient / legal representative the nature, purpose, benefits, material risks and alternatives to the proposed treatment as well as the risks and consequences of not proceeding with the treatment. I have offered to answer any questions and have fully answered all such questions to his or her satisfaction. I believe that the patient / legal representative understands what I have explained.

**PROVIDER SIGNATURE:** Date: Time:



597130

(05/10/2019)

CHI Franciscan

**CONSENT FOR PROCEDURE/TREATMENT**
**ELECTROPHYSIOLOGY STUDY WITH RADIOFREQUENCY**

PATIENT INFORMATION