Patient Identification
Name:______________________________
Medical Record Number: __________________
Birthdate: ___________________________

CONSENT FOR MEDICAL AND SURGICAL PROCEDURES: **Operative Vaginal Delivery**

You have the right and obligation to make decisions concerning your healthcare. Your physician/practitioner has the duty to provide you with the necessary information and advice; however you are responsible to participate in the decision-making process. Please feel free to ask any questions. Your signature on this form acknowledges your understanding of and agreement to the treatment recommended by your physician/practitioner after being informed of the risks, benefits and alternatives.

1. I hereby authorize ____________________________________ (and the associates, assistants and/or residents s/he has described to me) to treat the following condition(s) which has (have) been explained to me, as follows:
Professional Language: Non-reassuring fetal heart tracing, maternal exhaustion

Ordinary or Lay Language: Baby's heartbeat showing signs of distress, too tired to push more

2. The procedure(s) planned for treatment of my condition(s) has (have) been explained to me by the responsible practitioner/physician (and/or any associate/assistant involved in my care) as follows:
Professional Language: Operative vaginal delivery (forceps or vacuum delivery)

Ordinary or Lay Language: Vaginal delivery with assistance of forceps/spoons on baby's head or suction cup on baby's head

3. Risks/Benefits of Proposed Procedure(s):

A. I have been informed that there may be significant risks associated with the procedure(s), including but not limited to severe loss of blood, infection, injury to blood vessels, injury to adjacent organs, cardiac arrest, and other consequences that can lead to death or permanent or partial disability. In addition, specific risks associated with this procedure are as follows: Anal sphincter injury, injury to baby including intracranial hemorrhage, hematoma, blindness, bruising, or nerve damage

B. The material benefits of having the procedure(s) have been explained to me as:
Timely delivery of baby

C. The alternatives to the procedure(s) have been explained to me and include:
Expectant management

4. Complications/Unforeseen Conditions/Results: I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

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KAPI'OLANI MEDICAL CENTER FOR WOMEN & CHILDREN

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5. **Blood Transfusion:** I consent to transfusion of blood products (including whole blood, red blood cells, plasma, cryoprecipitate, platelets, and other products) as directed by the responsible practitioner/physician during the course of this treatment. I further understand, however, that I may at any time refuse transfusions and I will notify the responsible practitioner/physician if I choose to do so. I have been informed of the risks of transfusion(s) which include, but are not limited to, fever, chills, hives, rashes, rapid heart rate, clotting, infections such as hepatitis and AIDS, shock and death. The reasons for and availability of autologous blood (retransfusion of my own blood) as it applies and blood substitutes have been explained to me.

   For Patients Refusing Blood Products: Strike through and initial above paragraph (physician and patient).

6. **Photography:** I consent to photography, videotaping, televising or other audio and/or visual recording of this operation, postoperative care, medical treatment, anesthesia or other procedures for medical or scientific purposes or for the purpose of advancing medical education, provided my identity is not revealed by the pictures, by the recording, or by the descriptive texts accompanying them.

7. **Acknowledgments:** The available alternatives, the potential benefits and risks of the proposed procedure(s), and the likely result without such treatment have been explained to me. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

8. **Consent to Procedure(s) and Treatment:** Having read this form, talked with the responsible practitioner(s)/ physician(s), and been given the opportunity to ask questions, my signature below acknowledges that: I have all of the information I need to make an informed decision regarding this procedure, and voluntarily give my authorization and consent to the performance of the procedure(s) described above, including disposal of tissue, by the practitioner./physician and/or his/her associates assisted by hospital personnel and other trained persons as well as the presence of observers (e.g. vendors, students) for the purpose of advancing medical education. I also understand that physicians who are in approved post graduate residency training programs may perform portions of the surgery, based on their availability and level of competence and under the supervision of the operating practitioner.

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______________________________________	__________	__________
Signature of Patient (or person authorized to sign for patient)	Date	Time

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Relationship of Person Authorized to Consent for Patient

______________________________________	__________	__________
Signature of Responsible Practitioner/Physician	Date	Time

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☐ Telephone Consent – Witness to check here if telephone consent obtained (indicate name of consenting party and relationship to patient on above line) – 2 witnesses required per policy

______________ / ______________		__________	__________
Witness Signature	Witness Signature	Date	Time

______________ / ______________
Print Name Print Name
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