CONSENT FOR PACEMAKER AND/OR DEFIBRILLATOR WITH LEAD EXTRACTION AND/OR REVISION/GENERATOR EXCHANGE

DOCTOR(S)	and/or
ohysician associates ha	as/have discussed my medical problem with me and has/have explained the following procedure(s) to be undertaken
n lay terms completely	y understandable to me. I understand that my physician/surgeon may designate assistants, associates, residents,
nterns, technical assista	ants, and other health care providers as deemed necessary to assist him/her with the procedure(s) listed below.
☐ Implant of Pacer	maker and Lead Insertion
☐ Implant of Auton	natic Defibrillator and Lead Placement
Li impiant di Auton	Talle Delibrillator and Lead Flacement
☐ Implant of Biven	tricular Pacemaker
☐ Implant of Auton	natic Defibrillator with left ventricular lead placement for biventricular Pacing
_	· · · · · · · · · · · · · · · · · · ·
□ Pacemaker Gen	erator Exchange
☐ Automatic Defibi	rillator Generator Exchange
☐ Pacemaker and/	or Defibrillator lead Extraction

- I have been fully informed and understand the potential benefits, risks and side effects of this care and also the likelihood of achieving goals related to this
 procedure. Any potential problems that might occur during recuperation have been explained to me. I have also been informed about reasonable alternatives
 and the risk of not receiving this procedure.
- 2. I have been fully informed of and understand the complications and the medically acceptable alternative(s) to the above-describe procedure(s). These risks or complications may include but not limited to:

Fainting; Very fast or very slow heart; Infection; Loss of blood; Pain; Allergic reaction; or Perforation of the blood vessel or other damage to the arteries requiring an emergency surgical procedure to restore circulation. A very small percentage of patients who have the above procedures performed develop more serious complications such as Heart Attack; Heart failure; and rarely paralysis or loss of a limb; stroke; or death. Pericardial Effusion with may require surgical drainage/intervention.

- 3. I understand that my physician may discover other or different conditions which may require different procedures than those planned. If any unforeseen condition should arise during the course of the procedure, I do hereby authorize and request that the physician/surgeon and such associates, technical assistants, and other health care providers take whatever steps necessary to perform whatever procedure(s) they deem advisable, which may be in addition to or different from those now planned and have been discussed with me.
- 4. I have been made fully aware and acknowledge that the practice of medicine and surgery is not an exact science and that no guarantees or assurances have been made to me regarding expected outcomes. Although this procedure and its complications have been explained to me, I acknowledge that I have been given no guarantee against complication or assurance of success from the physician who explained the procedure to me. I know I have been given free choice to accept or reject any or all of the above procedures to be performed.
- 5. I consent to the proposed procedures(s) by the above physician(s) and (their) associates

JFK Medical Center, Atlantis, FL 33462 CONSENT-PACEMAKER-DEFIBRILLATOR WITH LEAD EXTRACTION OR REVISION-GENERATOR EXCHANGE



TREAT JFK-746-01146 Rev. 10/16 Page 1 of 2

Use of Blood Products

I understand the risks and possible need for use of blood products and I DO / DO NOT (Circle One) consent to the administration or transfusion of blood or blood products to me during my procedure and/or its related treatment whenever deemed necessary by those physician(s) attending to me, with no warranties made in connection with such blood or blood components.

Disposal of Tissue

I consent to the disposal by hospital authorities of any tissue, parts, organs, or extremities/limbs that may be removed in connection with my procedure(s). Tissues and/or organs, no longer needed for diagnostic purposes, may be used and/or photographed for research and educational purposes at JFK Medical Center, and its teaching facilities or for publication in an article related to medical research for the purpose of medical education.

Photographs/Observers

I consent to the taking of photographs, videotaping or other recordings in the course of this procedure for the purpose of advancing medical education as may be authorized by my physician(s) and to the admittance of qualified observers to the operating/procedure room as determined by the hospital.

Medical Device

To comply with the provision of the Safe Medical Act of 1990. I consent to the release of my social security number for tracking purposes.

Contrast Media

I understand the risks and consent to administration of contrast media (dye) during specific diagnostic procedures whenever deemed necessary by the physician(s) attending to me. I assume all risks in connection with use of contrast media that include, but are not limited to, allergic reaction, nausea, thrombophlebitis, hives, or renal failure. Very rarely an asthmatic attack, fall in blood pressure, or cardiac arrest can occur and medical treatment may be required to correct these conditions. In extremely rare conditions, a fatal reaction has occurred.

I have read and understand all of the above, have had an opportunity to ask questions concerning my planned procedure(s), and my questions have been answered to my satisfaction See below

ignature of Patient	Print Name	Date	Time
patient is unable to consent or is a minor, com	plete the following: Patient is unable to c	onsent because	
ignature of Authorized Representative	Print Name	Date	Time
elationship to Patient			
/itness (Signature &Title)	Print Name	Date	Time
Has been fully informed by me or my physici the medically acceptable alternative(s) to treassociated with the procedure(s); and the like Has authorized the performance of the procedure.	an associates, in lay terms understandal eatment, including refusal, and the conse selihood of the patient achieving his/her of	quences and risks to the patie	
Physician's Signature	Print Name	Date	

Patient Identification/Label

TREAT JFK-746-01146 Rev. 10/16 Page 2 of 2