

**Informed Consent for Operative / Invasive Procedure CP2.10**

Date \_\_\_\_\_ Time \_\_\_\_\_

I, the undersigned, consent to the following operation(s) and / or procedure(s); **Magnetic Resonance Imaging (MRI) with IV Gadolinium-based Contrast Material (GBCM)**

to be performed by Dr. \_\_\_\_\_ and his / her associates and assistants, as indicated below, with knowledge that the primary physician will have primary responsibility for my care specific to the stated procedure.

I understand that physicians who are fellows or residents (resident physicians), may also be involved in the procedure(s), including performing one or more significant task. I further understand that if resident physicians are involved:

- They will perform portions of the procedure(s) based on their level of competence;
- It will be decided at the time of the procedure(s) which resident physicians will participate and their manner of participation, taking into account the following factors: 1) my condition, 2) the availability of resident physicians with the necessary competence, and 3) the knowledge of the supervising physician of the resident physicians' skill sets;
- Any resident physicians performing significant tasks will be under the supervision of their supervising physician, though based on the resident physicians' level of competence, the supervising physician may not be physically present in the same room for some or all of the tasks performed by resident physicians.

**I have had the opportunity to ask any questions that I have regarding resident physician involvement.**

As listed below, certain significant tasks may be performed by qualified medical practitioners who are not physicians, acting within their scope of practice as permitted by State law and their clinical privileges granted by the hospital.

**Practitioner Type (check one):**

- Advanced Registered Nurse Practitioner  
 Physician Assistant  
 Certified Registered Nurse Anesthetist  
 Other \_\_\_\_\_

**Significant Task(s) to be Performed**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dr. \_\_\_\_\_ has explained to me the nature and purpose of each operation(s) and / or procedure(s) as well as the substantial risks and possible complications involved, the benefits and the medically reasonable alternative methods of treatment.

The **SUBSTANTIAL RISKS** include but are not limited to (add additional risks as indicated):

- perforation and / or injury to adjacent blood vessels, nerves and / or organs  
 bleeding  
 infection

Nephrogenic Systemic Fibrosis (NSF) in patients with renal insufficiency, chronic kidney disease or acute kidney injury. NSF may result in fibrosis of the skin and joints and cause significant limitation of motion within weeks to months. NSF may cause fibrosis of the internal organs, which could result in serious injury and death.

The **POTENTIAL BENEFIT(S)** include but are not limited to: diagnosis of disease process

The **MEDICALLY REASONABLE ALTERNATIVE(S)** options are: Magnetic Resonance Imaging (MRI) without gadolinium-based material or imaging by another modality, such as computerized tomography (CT), ultrasound (US), conventional angiography

**Shands  
HealthCare**  
**Facility:**  
**Shands at UF**  
*please print facility name*

This form provided by Shands as a courtesy to physicians and their patients.



AC0001

*If printed electronically,  
pages 1 & 2 must be stapled.*

**Operative / Invasive Procedure  
Informed Consent (page 1 of 2)**

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Patient Name:

Patient Identification #:

- I understand and consent to Shands' disposing of any tissue, parts or organs that are removed during the operation(s) and / or procedure(s), in accordance with its usual practice.
- I understand that the information I have received about risks is not exhaustive and there may be other, more remote risks.
- I have had the opportunity to ask questions regarding the proposed procedure(s) and all my questions have been answered to my satisfaction.
- I have read or have had read to me, this Operative / Invasive Procedure Informed Consent form.
- I have had explained to me, and I understand the potential benefits and drawbacks, potential problems related to recuperation, the likelihood of success, the possible results of non-treatment, and any medically reasonable alternatives.
- I have received no guarantees from anyone regarding the results that may be obtained.
- I know the relationship, if any, of my physician or other practitioner, to any teaching facility involved in my care.

My initials below indicate whether or not I consent to additional operations and / or procedures as are considered diagnostically or therapeutically necessary.

\_\_\_\_\_ **I consent OR**  
 \_\_\_\_\_ **I do not consent**

to additional operations and / or procedures as are considered diagnostically or therapeutically necessary on the basis of findings during the course of the operation(s) and / or procedure(s) described above and I accept the risks that may be associated with such additional operation(s) and / or procedure(s).

My initials below indicate whether observers may be present during my procedure, in accordance with my physicians' approval and hospital policy.

\_\_\_\_\_ I give permission to allow observers in the room during my procedure.  
 \_\_\_\_\_ I do not give permission to allow observers in the room during my procedure.

**CONSENT**

I do hereby consent to the above described operation(s) and / or procedure(s).

Patient Signature \_\_\_\_\_ Patient Printed Name \_\_\_\_\_  
 Witness Signature \_\_\_\_\_ Witness Printed Name \_\_\_\_\_

**SIGNATURES FOR CONSENT WHEN GIVEN BY REPRESENTATIVE OF PATIENT**

If patient is unable to consent, complete the following:

- Patient is a minor, or
- Patient is unable to consent because: \_\_\_\_\_

Patient's Name \_\_\_\_\_  
 Representative's Signature \_\_\_\_\_  
 Representative's Printed Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Witness Signature \_\_\_\_\_ Witness Printed Name \_\_\_\_\_

**SIGNATURES OF PHYSICIAN WHO OBTAINED CONSENT**

I certify that the procedure(s) described above, including the substantial risks, benefits, possible complications, anticipated results, alternative treatment options (including non-treatment) and their attendant risks and benefits, the likelihood of success and the possible problems related to recuperation, were explained by me to the patient or his / her legal representative.

Date \_\_\_\_\_ Time \_\_\_\_\_  Consent obtained by telephone.  
 Consent obtained with use of interpreter.  
 Name of interpreter \_\_\_\_\_

Signature of Physician Who Obtained Consent \_\_\_\_\_  
 Physician Identification Number \_\_\_\_\_