

OPERATION OR PROCEDURE

1. I, _____ parent/ legally authorized representative
of _____ authorize Dr/PA/NP

to perform the following operation or procedure: **FLEXIBLE BRONCHOSCOPY PLUS: LAVAGE;
 BIOPSY; LARYNGSCOPY; CILIARY BIOPSY.**

I understand the reason for the procedure or operation is: **TO EVALUATE THE AIRWAY AND: TEST FOR
INFECTION AND INFLAMMATION; LOOK FOR CAUSES OF LUNG DISEASE.**

2. Alternatives to this operation or procedure have been fully discussed with me by the provider named above.
Alternatives include: (must complete, if the only alternate course is no treatment, state "no treatment")

NO PROCEDURE

3. **Risks and Benefits:** I give this authorization with the understanding that any operation or procedure may involve certain risks or hazards. I understand that such risks include, but are not limited to infection, bleeding, nerve injury, blood clots, allergic reactions and pneumonia. These risks may result in serious consequences including death. The significant risks of this particular procedure include:

LOW OXYGEN, COUGH, CHEST PAIN, FEVER, BLEEDING, INFECTION, AND AIR LEAK (PNEUMOTHORAX)

The risks of not having this operation or procedure include: **LESS UNDERSTANDING OF RESPIRATORY DISEASE**

The benefits of having this operation or procedure include: **MORE UNDERSTANDING OF RESPIRATORY DISEASE**

4. **Anesthesia:** I understand anesthesia will be used to make the procedure as safe and comfortable as possible and that administration of anesthesia also involves risks. I understand such reactions are rare but the possibility exists. These risks may include but are not limited to possible damage to mouth or teeth, hoarseness, nausea or vomiting, drowsiness, difficulty urinating. More serious, although rare risks include awareness under anesthesia, changes in blood pressure and heart rate, visual problems, inhalation of stomach contents, fluid on the lungs, organ failure, malignant hyperthermia, drug reactions, coma, and death. When regional anesthetic techniques are used, risks are rare and may include but are not limited to prolonged numbness, spinal headache, backache, failure of technique, infection nerve damage, persistent numbness, weakness, and seizures. I consent to the use of such anesthetics as may be considered necessary by the person responsible for administration of these medications or anesthetics. I understand these and other risks related to or associated with the giving of anesthetics as well as potential alternatives will be discussed with me by the anesthesiologist.

5. **Additional Procedure:** If my physician/dentist/provider discovers a different unsuspected condition at the time of surgery, I authorize him/her to perform such operation or procedure that he/she deems necessary.

6. I hereby authorize the physician/dentist/provider and Children's Hospital Colorado to preserve for scientific or teaching purposes, or to dispose of any tissues, body parts, or organs removed as a necessary part of my (the patient's) care except as noted:

NONE



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OPERATION OR PROCEDURE**
(rev. 10/2014)

CONSENT PROCEDURE
Page 1 of 2

Place Patient Identification Label Here

7. I understand that no guarantee or assurance has been made as to the ultimate result of the operation or procedure. It may not cure the condition for which it is performed.

I also understand Children's Hospital Colorado is a teaching institution and that the physicians in training may actively participate in the pre-operative and post-operative care of the patient as well as the operation itself.

All levels of participation by the physicians in training will be under the direction of the physician/provider named above.

8. Patient's/Patient's Legally Authorized Representative's Consent: I have read and fully understand this consent form. I understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the words contained in this form.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED OPERATIONS OR PROCEDURE OR PRESCRIPTION OR ANY OTHER QUESTIONS CONCERNING THE PROPOSED OPERATION OR PROCEDURE OR PRESCRIPTION, ASK YOUR PHYSICIAN/PROVIDER NOW **BEFORE SIGNING THIS CONSENT FORM.**

Date	Time	Patient or Person with authority to consent for patient
Relationship to Patient		
Witness to signature if telephone consent		

9. Physician Declaration: I have explained the contents of this document to the patient and/or the patient's legally authorized representative and have answered all the patient's/legally authorized representative's questions to the best of my knowledge, and have adequately informed the patient and/or legally authorized representative who has consented to the operation or procedure detailed above.

Physician/Dentist/PA/NP Signature	Date	Time
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Informed consent discussion interpreted for patient/representative by:

Declined preferred language consent



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CONSENT PROCEDURE
Page 2 of 2

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