

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES
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A. IDENTIFICATION

1a. (Place 'Y' for YES, 'N' for NO in all applicable boxes)

Y	OPERATION OR PROCEDURE		SEDATION
	ANESTHESIA	N	TRANSFUSION

1b. DESCRIBE

Anatomical Location: N/A
Incision and Drainage of Soft Tissue
Transfusion not expected

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language). **See attached Procedure Detail Sheet**

Which is to be performed by or under the direction of Dr. , other staff and Resident team.

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.
4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.
5. Exceptions to surgery or anesthesia, if any are: None (If "none", so state)
6. I request the disposal by authorities of the below-named medical facility of any tissues or parts which may be necessary to remove.
7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions: **Yes**
 - a. The name of the patient and his/her family is not used to identify said pictures.
 - b. Said pictures be used only for purposes for medical/dental study or research.
8. I understand that as indicated a Health Care Industry Representatives or other authorized personnel may be present.

C. SIGNATURES

(Appropriate items in parts A and B must be completed before signing)

9. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

(Signature of Counseling Physician/Dentist)

10. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed:

(Signature of Witness, excluding members of operating team)

(Signature of Patient)

(Date and Time)

11. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) _____

sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Sponsor or Guardian)

(Date and Time)

**REQUEST FOR ADMINISTRATION OF ANESTHESIA
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OTHER PROCEDURE**

Medical Record

DETAILS OF PROCEDURE/TREATMENT**(Descriptive information about the specific procedure(s)/treatment(s) being performed)****Procedure/Treatment Description**

This procedure involves making an incision to drain blood or other fluid from the affected area. You may be given medicine to numb any pain. Your doctor will make an incision (surgical cut). The fluid or blood will be drained and collected. Dead tissue may be removed. Your doctor may also remove some overlying skin. Your doctor may send a sample of the fluid or tissue to the lab to be tested.

A tube may be placed to drain air and fluid. Sometimes, a wound vacuum may be needed. This is a device that attaches to a tube to draw out air and fluid. Special dressing used with the wound vacuum will need to be changed as recommended by your doctor. You may need to have additional procedures to close the wound.

Diagnosis

An abnormal collection of blood or other fluid in the soft tissue(s). This may be a blister, seroma, hematoma, or abscess.

Benefits of treatment(s) or procedure(s)

This procedure may improve or cure your symptoms. These may include pain or infection.

Reasonable risk / complications of surgical treatment(s) or procedure(s)

- * Bleeding.
- * Bruising and/or swelling at the treatment site.
- * Pain, numbness, swelling, weakness, or scarring where tissue is cut.
- * Scar(s). Scars may be painful. They may limit function or range of motion. They also may not look the way you want them to.
- * The procedure may not cure or relieve your condition or symptoms. They may come back and even worsen.
- * Your doctor may not be able to make a proper diagnosis.
- * Abnormal collection of blood in an area that may need drainage.
- * Reaction to local anesthesia or other medicines given during or after the procedure.
- * You may need additional tests or treatment.
- * Wound infection, poor healing, or reopening of the incision(s). Blood or clear fluid can also collect at the wound site(s). Infection may require antibiotics and additional surgery.
- * An abscess or buildup of pus may form. It may require drainage or additional surgery.
- * Damage to nerves, blood vessels, muscles, tendons, skin, and other structures surrounding the treatment area.
- * Accidental injection of the local anesthetic into a blood vessel. This may cause allergic reaction, seizures, irregular heartbeat, cardiopulmonary arrest, and death. It may affect your brain temporarily or permanently. This may disturb heart and lung function.

Additional Risks Discussed (if applicable):**Alternatives to surgical treatment(s) procedures(s)**

- * Watching and waiting with your doctor.
- * Treatment with antibiotics.
- * Temporary placement of a small tube to drain blood or fluid.
- * Aspiration. This involves withdrawing fluid using a hollow needle. No incision would be needed.
- * You may choose not to have any treatment.

Prognosis if not treatment is received

If you choose not to have this procedure, your symptoms may continue or get worse.

Blood Transfusion (if applicable): Transfusion not expected

Name of Interpreter (if applicable):

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OPTIONAL FORM 522 (REV. 7/2008)
Prescribed by GSA/ICMR FMR (41 CFR) 102-194.30(i)
DoD Exception to OF 522 approved by GSA

Procedural Time-Out (Universal Protocol checklist)

Procedure(s) to be performed is: INCISION → DRAINAGE

1. Preoperative Verification Process, required for all procedures. (Check the appropriate blocks – either performed (Yes), or not applicable/required (N/A))

a. Patient/parent/legal guardian verbally states 2 identifiers (e.g. name/SSN/birth date)	Yes	(required for all procedures)
b. Correct name on chart/record/consent/radiographs	Yes	(required for all procedures)
c. Consent verified for planned procedure completed accurately and signed	Yes	(required for all procedures)
d. H&P within 30 days and updated within the 24 hours prior to procedure	Yes	N/A
e. Patient allergies	NKDA	Reviewed and Confirmed
f. Required blood products/implants/devices/graft material/studies/special equipment	Yes	N/A

2. Site Marking: (Check "Yes", or "N/A" if marking is not required)

a. Patient/parent/legal guardian verbalizes and points to location of surgery	Yes	N/A	
b. Correct surgical procedure and surgical site marked	Yes	N/A	Unable to Mark

3. Surgical Pause "Time Out" - Immediately before starting procedure

a. Correct patient identity verbally verified by staff – use 2 pt identifiers (e.g.(name/SSN/birth date)	Yes	(required for all procedures)
b. Correct side, and site and level marked	Yes	N/A
c. Any required blood products, implants, devices and/or special equipment is available	Yes	N/A
d. Correct patient position	Yes	N/A
e. Labeled diagnostic and radiology images displayed	Yes	N/A
f. Antibiotic administered	Yes	N/A
g. Mark is visible after drape – make incision <u>only</u> if initials are visible and correct Or provider has specified "Unable to Mark" above	Yes	N/A
h. All members of the procedure team are in agreement on procedure to be performed or a patient safety Time-Out is called (see table below)	Yes	N/A

• Site is confirmed with patient but unable to mark:	# Critical Steps Reviewed:
<ul style="list-style-type: none"> • Patient refuses marking • Premature infant • Technically/anatomically not able to be marked • Single midline organ • Site not predetermined – interventional procedures, spinal analgesia, etc. • Teeth <ul style="list-style-type: none"> • Review the dental record including the medical history, laboratory findings, appropriate charts, and dental radiographs. • Indicate the tooth number(s) or mark the tooth site or surgical site on the diagram of teeth or radiograph to be included as part of the patient record. • Correct site verified 2nd time following single tooth isolation 	<ul style="list-style-type: none"> • Surgeon Review <ul style="list-style-type: none"> • Critical or unexpected steps • Operative duration • Anticipated blood loss • Anesthesia Review <ul style="list-style-type: none"> • Previous issues with anesthesia or peri-operative bleeding • Airway status • Any patient-specific concerns • FSBG or b-HCG • Nursing Review <ul style="list-style-type: none"> • Sterility confirmation (including indicator results) • Equipment issues or any concerns

Verified by: _____ Date & Time: _____

Exception to time-out documentation above: By checking this block, I certify that I have performed and documented the required time-out procedures, as described above, in another document or format. (This includes either a written or electronic pre-operative nursing form, procedure note, or clinical / progress note, which is readily available for verification.)

Provider / Assistant signature: _____ Date & Time: _____

Register No.

Clinic/Ward No.

PATIENT'S INFORMATION: (For typed or written entries give:

Name – Last, First MI, grade, rank, rate, SSN, DOB, and hospital or medical facility)