

Laparoscopic Cholecystectomy Consent

This information is given to you so that you can make an informed decision about having **Laparoscopic Cholecystectomy Surgery**.

Your gallbladder stores bile, a fluid made by your liver. Too much bile or bile not emptying from the gallbladder can cause gallstones. Gallstones can block the flow of bile in your digestive system. This blockage can cause bloating, nausea, vomiting, and pain in your abdomen, shoulder, back, or chest. Gallstones can also block the ducts that channel the bile from the liver or gallbladder to the intestine. Gallstones can cause the gallbladder to become infected. A blockage in the common bile duct can cause jaundice (yellowing of your skin or eyes) or irritate the pancreas. Surgical removal of the gallstones or gallbladder is the best treatment.

A laparoscope is a small, thin tube that is put into your body through a tiny cut made just below your belly button. Your abdomen is inflated with carbon dioxide, a harmless gas. A cholangiogram (a special X-ray) is done to check for stones in your common bile duct. Your surgeon can see your gallbladder on a television screen. The surgery is done with tools inserted in three other small cuts made in the right upper part of your abdomen. Your gallbladder is taken out through one of the incisions

Benefits of this Surgery

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- You may return to work sooner than with traditional surgery.
- You may have less pain with a shorter hospital stay.
- Shorter recovery time.
- Smaller scars.

Risks of Surgery

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

Risks of this Surgery

- The intestine may be injured. This would require more surgery.
- Excessive bleeding could occur if nearby blood vessels are injured.
- Injury to the bile duct. This would lead to an open procedure.
- Shoulder pain and bloating from air inserted in the abdomen during the procedure.
- If there are complications the procedure may be changed to an open procedure. This would cause a larger incision and longer recovery.

General Risks of Surgery

- **Small areas of the lungs may collapse.** This would increase the risk of infection. This may need antibiotics and breathing treatments.
- **Clots may form in the legs, with pain and swelling.** These are called DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go to the lungs. This can be fatal.
- **A strain on the heart or a stroke may occur.**
- **Bleeding may occur.** If bleeding is excessive, you may need a transfusion.

- **Reaction to the anesthetic may occur.** The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you. **Insert type of anesthesia if known.**

Risks Associated with Smoking

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Associated with Obesity

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Specific to You

Alternative Treatments

Other Choices:

- Do nothing. You can decide not to have this procedure.

If you choose not to have this treatment

- Your symptoms of pain, nausea, vomiting may continue.
- You could become seriously ill with infection.

General Information

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more tests or treatment.
- Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.
- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected

Patient Name: _____

DOB: _____

By signing this form I agree

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: **Laparoscopic Cholecystectomy Surgery** _____
- I understand that my doctor may ask a partner to do the procedure.
- I understand that other doctors, including medical residents or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. IF so, please obtain consent for blood/product.

Patient Signature _____ Date: _____ Time: _____

Relationship: Patient Closest relative (relationship) _____ Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: _____ Date _____ Time _____

Interpreter (if applicable)

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

OR

____ Patient elects not to proceed: _____ Date: _____ Time: _____

(patient signature)

Validated/Witness: _____ Date: _____ Time: _____