

MEDICAL RECORD

**REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES**

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
Intrauterine Device (IUD) Removal
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**
- The name of the patient and his/her family is not used to identify said pictures.
 - 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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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

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

This procedure involves removing a small plastic or copper device from your uterus through the cervix. The cervix is the lower, narrow end of the uterus that opens up into the vagina. The uterus, or womb, is where the baby grows during pregnancy. The device is called an IUD. This stands for intrauterine device.

Your provider will do a pelvic exam to determine the exact position of the uterus.

After the exam, a speculum will be inserted into your vagina. This instrument holds the vagina open. You might need to have an instrument inserted to hold the cervix in place and keep your uterus steady. This is called a tenaculum.

Your provider will grasp the strings of the IUD that are hanging from your cervix. The strings will be gently pulled. The IUD will come out of your uterus.

In the unlikely case that the string has retracted into the cervix or uterus, your doctor may probe the cervix with a long, narrow clamp. If the string still cannot be found, your doctor may stretch open your cervix to look for the string. Your doctor may use an instrument called an IUD hook. This hook will be placed inside the uterus to remove the IUD. Your doctor may even place a small telescope into the cervix to look for the string or IUD. If the IUD cannot be located, your doctor may do other tests. These may include x-rays, ultrasound, CT, MRI, or more telescopic studies to locate it.

Diagnosis

To stop using the device as the method of birth control. To stop using the device due to side effects such as infection, bleeding, or pain.

Benefits of treatment(s) or procedure(s)

This procedure may make it possible for you to get pregnant. It may reduce symptoms or problems caused by the IUD.

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

- * Cramping, bleeding, or spotting.
- * No guarantee that fertility or pregnancy will be achieved.
- * You may become pregnant.
- * Your doctor may not be able to remove the device. You may need additional treatment.
- * If you are pregnant, removal of the IUD may cause miscarriage (spontaneous abortion). However, there is an increased risk for miscarriage and preterm delivery if the IUD is left in place.
- * Infection.
- * The device or equipment used to do the procedure may not work correctly.
- * You may need additional tests or treatment.
- * Damage to the uterus or nearby structures. This may be discovered during the procedure or later.

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

- * Leaving the IUD in place. This is only possible if the current IUD is not expired.
- * Having a new IUD inserted immediately following removal of the original IUD.
- * You may choose not to have this procedure.

Prognosis if not treatment is received

If you choose not to have this procedure, you may not be able to get pregnant. If your IUD is expired, you may develop health problems. You may have an unplanned pregnancy. This could be an ectopic pregnancy. Ectopic pregnancy is an emergency. You could hemorrhage. Hemorrhage can cause death.

Blood Transfusion (if applicable): Transfusion not expected

Name of Interpreter (if applicable):

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DoD Exception to OF 522 approved by GSA

Procedural Time-Out (Universal Protocol checklist)

Procedure(s) to be performed is: IUD REMOVAL

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

<ul style="list-style-type: none"> Site is confirmed with patient but unable to mark: 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 	# Critical Steps Reviewed: <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
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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)