| 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) | | | | 1b. DESCRIBE |
|---|---|---|---|---|
| **Y** | OPERATION OR PROCEDURE | | SEDATION | **Anatomical Location: N/A** |
| | ANESTHESIA | **N** | TRANSFUSION | **Subcutaneous Contraceptive Implant Removal with Insertion of a New Implant**<br>**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)* |

## DETAILS OF PROCEDURE/TREATMENT

**(Descriptive information about the specific procedure(s)/treatment(s) being performed)**

**Procedure/Treatment Description**
This procedure involves removing a previously placed contraceptive implant that was placed just under the skin of your arm and replacing it with a new one.

Your provider will first locate the implant. This is done by feeling the area or by ultrasound or other imaging methods, if needed. Your provider will numb the area. This is done with a medicine that is sprayed on the area or injected into the skin. Your provider will then remove the implant through a small incision (surgical cut) in the skin. If the implant has shifted, is broken, or is stuck in the tissue, the removal could take longer. A larger incision may be needed.

Your provider will be able to replace the implant through the same incision used for the removal. If a different site is used, your provider will numb that area. Your provider will then make a small incision in the skin to insert the new implant.

Your provider will apply a pressure bandage to the site(s). This is done to reduce bleeding and decrease swelling.

**Diagnosis**
A subcutaneous contraceptive implant that is expired or not working. To place a new implant.

**Benefits of treatment(s) or procedure(s)**
This procedure may keep you from getting pregnant.

**Reasonable risk / complications of surgical treatment(s) or procedure(s)**
* Acne.
* Bleeding.
* Bruising and/or swelling at the treatment site.
* Cramping, bleeding, or spotting.
* Depression.
* Headaches.
* Irregular periods.
* Mood changes.
* Pain, numbness, swelling, weakness, or scarring where tissue is cut.
* Palpability of the implant. You and others may be able to feel the implant under the skin.
* Undesirable cosmetic effects or scarring.
* Unintended pregnancy.
* Your doctor might not be able to place the device in the desired location. It could move later.
* Reaction to local anesthesia or other medicines given during or after the procedure.
* Movement of the implanted device which could cause changes in functioning, pain, bleeding, or tissue damage.
* 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.
* Allergic reaction. May include itching, hives, swelling, difficulty breathing, drop in blood pressure, and possible loss of consciousness.
* Arterial thrombotic and venous thromboembolic events. These may include pulmonary emboli (some fatal), deep vein thrombosis, heart attack, and stroke.
* Risk of ectopic (outside the uterus) pregnancy.
* The implanted device may bend, break, fail, or become infected. You may need surgery to reposition, remove, or replace it.

**Additional Risks Discussed (if applicable):**

**Alternatives to surgical treatment(s) procedures(s)**
Alternative therapy options may include medical and surgical treatments. Your doctor will discuss the specific risks and benefits as they relate to your condition.
* Having the implant removed and not replacing it.
* Other forms of birth control. These may include:
    * Barrier contraceptives such as condoms, sponges, or diaphragms.
    * Hormonal birth control pills, injections, patches, or IUD.
    * Non-hormonal IUD.
    * Tubal ligation or vasectomy. These are permanent forms of birth control.
* You may choose not to have this procedure.

**Prognosis if not treatment is received**
If the implant is not removed and it expires, you may unintentionally get pregnant if you do not use another form of birth control. If the removed implant is not replaced, you may unintentionally get pregnant if you do not use another form of birth control.

**Blood Transfusion (if applicable): Transfusion not expected**

Name of Interpreter (if applicable):

# Procedural Time-Out (Universal Protocol checklist)

Procedure(s) to be performed is: NEXPLANON REPLACEMENT

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

| | | | |
|---|---|---|---|
| a. | Patent/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 *only* 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: |
|---|---|
| • Patient refuses marking<br>• Premature infant<br>• Technically/anatomically not able to be marked<br>• Single midline organ<br>• Site not predetermined – interventional procedures, spinal analgesia, etc.<br>• Teeth<br>  • Review the dental record including the medical history, laboratory findings, appropriate charts, and dental radiographs.<br>  • 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.<br>  • Correct site verified 2nd time following single tooth isolation | • Surgeon Review<br>  • Critical or unexpected steps<br>  • Operative duration<br>  • Anticipated blood loss<br>• Anesthesia Review<br>  • Previous issues with anesthesia or peri-operative bleeding<br>  • Airway status<br>  • Any patient-specific concerns<br>  • FSBG or b-HCG<br>• Nursing Review<br>  • Sterility confirmation (including indicator results)<br>  • 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)