This form is available in multiple languages. Please use an interpreter and the appropriate consent form for patients who do not speak English.

SECTION A:

1. After discussing other options, including no treatment, with the responsible practitioner or his/her delegated representative, I give [insert name of person performing procedure] permission to perform the following surgery, procedure(s) or treatment [list name or description of operation(s), procedure(s) and/or treatment(s) - indicate applicable level, side, or site]:

   - Ventilation - Perfusion (VQ) Scan during Pregnancy

I understand that this procedure is for purposes of diagnosis and/or treatment for [describe reasons for procedure]:

   - Pulmonary Embolism (blood clot in the lung vasculature)

2. I give permission to my responsible practitioner to do whatever may be necessary if there is a complication or unforeseen condition during my procedure.

3. My responsible practitioner has explained to me in a way that I understand: (a) the nature and purpose of the procedure(s); (b) the potential benefits and risks of the procedure(s) including bleeding, infection, accidental injury of other body parts, failure to permanently improve my condition or, death, as well as the potential risks and benefits of the medications that may be administered to me as part of the procedure; and (c) the alternative(s) to the procedure(s) and their potential risks and benefits, including the option of not having the procedure.

   - Radiation exposure to the fetus and mother leading to a theoretical slight increased risk of cancer.

I understand that other things can happen as well.

4. I understand the purpose and potential benefits of the procedure. My responsible practitioner has explained to me what results to expect, and the chances of getting those results. I understand that no promises or guarantees have been made or can be made about the results of the procedure(s).

5. I agree to have anesthesia as necessary to perform the procedure(s). I understand that if an anesthesiologist is to be involved he/she will speak to me about the risks of anesthesia in more detail and I may be asked to sign a separate consent form.

6. I understand that my responsible practitioner may deem it necessary for me to have a blood transfusion during or after the procedure(s). I understand what a blood transfusion is, the procedures used, the benefits of receiving a transfusion and the risks involved. The benefits include better oxygen delivery to all parts of my body (for red blood cells) and treating or decreasing the risks of bleeding (for platelets and plasma products). The risks include: fever, chills, and allergic reactions which are generally mild and transient; on rare occasions major transfusion reactions occur such as rapid breakdown of blood cells and acute lung or kidney injury; and rarely bacterial, viral or other infections such as hepatitis B, hepatitis C, and human immunodeficiency virus (HIV). I understand these risks exist, although screening and testing of blood donors and their blood is performed to minimize these risks. My questions regarding alternatives have been addressed by my physician in relation to my specific circumstances.

   - I agree to receive transfusions of blood or blood products if medically necessary.
   - OR I refuse to receive any transfusions and understand that I may suffer severe injury or death as a result of my refusal and I will not hold my physician, the hospital or other healthcare personnel responsible for the results of that refusal.

   (One line must be initialed by patient)

7. I give permission to the hospital and/or its departments to examine and keep tissue, blood, body parts, or fluids removed from my body during the procedure(s) to aid in diagnosis and treatment, after which they may be used for scientific research or teaching by appropriate persons. If these things are used for science or teaching, my identity will not be released. I will no longer own or have any rights to these things regardless of how they may be used.

8. If the procedure listed above involves the implantation/transplantation of tissue from a human or animal source, my responsible practitioner has described to me the risks and benefits of receiving this product.

   1 In cases of refusal of blood by a parent or guardian of a minor, contact Legal and Risk Services immediately, as in most cases court intervention will be sought.
9. I understand that Yale-New Haven Hospital is a teaching hospital. Doctors or other health practitioners who are members of the care
team who are in training may help my practitioner with the procedure. I understand that these trainees are supervised by qualified staff
and the supervisor will be present at all important times during the procedure. I also understand that my practitioner’s associate(s),
surgical assistants and/or other non-physicians or trainees may assist or perform parts of the procedure under my doctor’s supervision, as
permitted by law and hospital policy. If others who are not hospital staff will be present in the operating room, my doctor has spoken with
me about this. I understand that a representative of an equipment vendor or a visitor may be present in the procedure area and that if that
occurs any visitor or vendor will comply with any applicable policy regarding observers in the Operating Room.

10. I give permission to the hospital and the above-named practitioner to photograph and/or visually record or display the procedure(s) for medical,
scientific, or educational purposes. I understand that I will not be identified to those not involved in my care unless a separate consent is signed.

11. In the event a healthcare worker is exposed to my blood or body fluids in connection with my procedure, or during my hospital stay, I agree
to the collection and testing of my blood for HIV.

12. I have read this form or had it read to me. I have had an opportunity to ask questions and to consider my decisions. All of my questions
have been answered to my satisfaction.

_____________________________            ___________________________            ___________________________            __/__/______ AM/PM
Signature of Patient Written Name   Date  Time

_____________________________            ___________________________            ___________________________            __/__/______ AM/PM
Signature of Person Obtaining Consent Form Written Name   Date  Time

_____________________________            ___________________________            ___________________________            __/__/______ AM/PM
Signature of Authorized Representative (person consenting for patient) Written Name   Date  Time

☐ patient too severely ill  ☐ patient unconscious  ☐ patient lacks capacity

Relationship to Patient

Name/code of the interpreter:  Company if other than hospital: __________________________

SECTION B – TELEPHONE CONSENT:
I have discussed in a witnessed telephone conversation all of the issues set forth in the CONSENT FOR OPERATION OR SPECIAL PROCEDURE
with the patient’s surrogate/family member. This included a discussion of the risks, their likelihood, and alternative treatment options as set forth
in Section A, above.

Consent was obtained by telephone on: __/__/______ AM/PM

Date  Time

Name of person who gave consent: __________________________

Relationship to Patient: __________________________

_____________________________            ___________________________            __/__/______ AM/PM
Signature of Person Obtaining Consent Written Name   Date  Time

_____________________________            ___________________________            __/__/______ AM/PM
Signature of Witness Written Name   Date  Time

Name/code of the interpreter:  Company if other than hospital: __________________________

SECTION C – EMERGENCY PROCEDURE:
The patient is in need of a procedure to save the patient’s life, limb or organ and is unable to consent for him/herself and family is currently
unavailable despite reasonable efforts.

_____________________________            ___________________________            __/__/______ AM/PM
Signature of Responsible Practitioner Written Name   Date  Time

SECTION D - MANDATORY SIGNATURE OF RESPONSIBLE PRACTITIONER:

_____________________________            ___________________________            __/__/______ AM/PM
Signature of Responsible Practitioner Written Name   Date  Time