Surgical Consent for Bronchoscopy

Diagnosis: ____________________________________________

Name of Procedure/Treatment:
• Bronchoscopy

Nature and purpose of proposed treatment:
• Bronchoscopy is the visualization of the trachea-bronchial tree (breathing area) for bleeding, growths and foreign bodies. Congestion may also be removed.

Risks common to all surgical procedures:
• Injury to a blood vessel or excessive bleeding. This may require a blood transfusion.
• Infection, which may require the use of antibiotics. In rare cases, another surgical procedure may be necessary to remove the infection.
• Complications with anesthesia. This may include nausea, vomiting, or in rare cases, death.
• Tobacco use, excessive alcohol use and obesity can increase the risk of any surgical procedure or general anesthetic. Any of these factors may substantially affect healing and can result in an increase of major complications including pneumonia, wound infection, blood clots in the legs and lungs, or death.

Risks and possible complications of the proposed treatment:
• Bleeding
• Airway injury
• Vascular (blood vessel) injury
• Nerve injury
• Hemo-pneumothorax which is bleeding into the chest which can cause the lung to collapse. A chest tube will be needed to drain the fluid and re-expand the lung
• Pain after surgery requiring the use of pain medicine
• Infections which may require the use of antibiotics. Sometimes another surgical procedure will be needed
• Scars at the incision site

Risks or complications of the proposed treatment that is specific and unique to the patient:
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Alternative Treatments:
• X-rays

Prognosis if the proposed treatment is NOT accepted:
• Disease process is undiagnosed and it will be difficult to make a plan of treatment

I understand the above information and give my consent to have the described treatment performed.

___________________________________  _____________________________________
Patient Signature                  Physician Signature

___________________________________  _____________________________________
Date                                Date