

CONSENT FOR SURGICAL AND MEDICAL PROCEDURES

Name of Patient _____

I hereby authorize Dr. _____ and assistants to perform the following operation/procedure
(Please print or type): _____

I understand that because the Hospital is a graduate medical education teaching site, interns, residents, and/or medical students, and other non-physician practitioners may also be in attendance and/or assisting in the performance of the above specified surgery and/or special procedure/treatment.

Operation/Procedure

My physician has explained to me the nature and purpose of the operation or procedure identified above and has informed me of the possible complications, risks, and possible benefits. Possible alternatives to the proposed procedure or treatment have also been discussed including having nothing performed. I understand during the course of the operation or procedure unforeseen circumstances may arise that may necessitate procedures different from or in addition to those contemplated. I consent to any additional procedures as my doctor or his/her associates consider necessary or advisable and consent to be treated for all such conditions.

I consent to the photographing or televising of the operation or procedures including portions of my (the patient's) body for medical or education purpose, provided my (the patient's) identity is not revealed by the pictures or by the descriptive text. I also consent to the presence of observers in the procedure room for the purpose of advancing medical education, providing technical advice or supporting medical technology.

I understand that organs or tissues surgically removed may be examined and retained by the Hospital for medical, scientific or educational purpose, and that such specimens may be disposed of in accordance with customary practice or as required by law.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that there are no guarantees concerning results from this or any other operation or procedure.

I understand that during the operation or procedure and in the immediate recovery period, every resuscitative effort will be made to keep me alive should the necessity arise, even if my Advanced Directive states that I not be resuscitated.

Transfusion of Blood or Blood Components

For procedures in which blood loss significant enough to warrant transfusion during my operation/procedure and/ or in the immediate postoperative period is possible, my physician has informed me of the risks and benefits of receiving transfusions/blood components. The risks and benefits of receiving transfusions/blood components have been explained to me and I understand that these risks exist despite the fact that the blood has been tested. Alternatives to transfusion, including the risk of no transfusion, have also been explained to me.

I have read and fully understand this form. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

Signature of Patient
(Next of Kin or Legal Representative)

Print Name

Legal relationship if not patient

Witness: Signature

Print Name of Witness

Date

Time

Physician's statement

I hereby certify that the nature purpose, benefits, risks of and alternatives to the proposed procedure/operation/transfusion have been explained and that the patient has had the opportunity to ask any questions and these were answered to the patient's satisfaction. I am satisfied that the patient or the patient's representative understands what has been explained and an informed consent has been provided.

Physician Signature

Date

SEE PAGE 2 FOR: Emergency Authorization, Telephone consent