



STATEMENT OF CONSENT

I request and authorize Dr. _____, and/or other doctors, assistants, students, and staff who may be assigned to my care, to perform on: _____
(Patient's Name or "Myself")
the following operation(s) or procedure(s): _____

(DO NOT ABBREVIATE)

When the procedure is planned for one side of the body, indicate the planned side here: RIGHT LEFT

A copy of this form will be used as authorization for **blood products and other services**.

I understand:

1. A physician has explained to me the nature, purpose, and risks of the proposed procedure(s). I have further had explained to me and discussed available alternative methods of treatment, including their risks, consequences, and probable effectiveness. I have also been informed of the possible results should this procedure not be performed. I understand the risk of complications, serious injury or even death that may result from both known and unknown causes. I have also been informed that there are other risks such as severe loss of blood, infection, cardiac arrest (heart attack), etc., that can occur in the performance of any procedure.
2. I have also had it explained to me that before, during, or after the procedure listed above, I may develop or the physician may discover new conditions which the physician could not foresee. These new conditions might make it necessary or advisable for additional or different procedures to be used in my diagnosis and treatment. I therefore request and authorize my doctors to use such additional or different procedures as they think necessary or advisable for my diagnosis or treatment.
3. I have been informed that an anesthetic may be administered to me by a member of the anesthesia staff (i.e. physician only, a physician supervised resident or a nurse anesthetist) for general or monitored anesthesia. For a local or conscious sedation procedure, the operating room surgeon directs a conscious sedation nurse. The alternatives and usual risks and benefits associated with its administration have been explained to me. I consent to the administration of such anesthesia. Restrictions, if any, on the type of anesthetic are described on the description of the procedure.
4. I agree to receive blood or blood products if deemed necessary by my physician(s). The benefits, risks and alternatives associated with blood product use have been explained to me, as well as the risks of refusing blood products. I understand that the blood products have been tested for hepatitis, HIV/AIDS, and some other pathogens. Blood products may or may not have been tested for bacteria and other pathogens. Testing reduces, but does not eliminate, the possibility that the patient may get these or other infections from the blood. Other occasional complications include allergic reactions such as hives, chills, fever and nausea. Other infrequent complications include rapid destruction of transfused blood, fluid excess in the lung, shock and severe allergic reactions. I understand that when the patient's medical condition permits, the patient may donate his/her own blood in advance for later transfusion. I understand that such blood donations are not free from risk and may not satisfy all blood requirements.



5. I understand that it is the practice of this surgery center and the physicians providing my care to temporarily suspend “do not resuscitate” (DNR) orders and I agree to such suspension. DNR orders may remain in effect during operations only with the written agreement of the surgeon and anesthesiologist.
6. The independent practitioners who have been granted privilege of using this facility for the care and treatment of patients are not employees or agents of the surgery center.
7. I also have been informed and understand that the practice of medicine, surgery and dentistry is not an exact science. No guarantees or promises have been made to me concerning the results of the procedure(s).
8. I consent to the observing, photographing, filming, televising, or recording of any of the procedure(s) to be performed for purposes of performance improvement, helping medical education or helping medical knowledge.
9. Any tissue, fluids or body parts removed during the procedure(s) may be disposed of or retained. I also consent to use of such tissue, fluids or body parts for research, except as noted here: _____.
10. I understand that, if part of my treatment includes implanting a medical device that falls under the tracking requirements of the Food and Drug Administration, my name and/or identifying information may be provided to the manufacturer of such medical device.

By signing below, I acknowledge (1) that I have read **BOTH SIDES OF THIS FORM**, (2) that I understand the form and information provided by my doctor or doctor’s designee, (3) that I have had the opportunity to ask questions and have had them answered to my satisfaction, and (4) that I hereby give authorization and consent to the performance of the operation(s) or procedure(s) listed above. The risks and benefits of, and viable alternatives to, the operation(s) or procedure(s) have been explained to me and I agree to proceed.

AUTHORIZING SIGNATURES:

_____ Signature of Patient or Person Authorized to Sign	_____ Physician Signature
_____ Print Name	_____ Print Physician Name
_____ Relationship to Patient	_____ Date
_____ Date Time <u>AM</u> PM	_____ Date Time <u>AM</u> PM

 Witness Signature*

 Print Witness Name

 Date Time AM
PM

 Interpreter or Reader Signature (if applicable)

 Print Interpreter or Reader Name

 Date Time AM
PM

* Only required if patient signature not obtained by physician or when telephone consent obtained.

**Consent to Operations, Anesthetics,
 or Other Procedures**