



You (the patient or person legally responsible for the patient) have the right as a patient to be informed about your condition and the recommended surgical, medical or diagnostic procedures to be performed so that you may make an informed decision as to whether or not to undergo the procedure after knowing the risks, benefits and alternatives. This disclosure is an effort to inform you so that you may give or withhold your consent to the procedure at any time prior to its performance.

I voluntarily request/consent _____ as my physician and such associates, students, technical assistants and other health care providers as my physician may deem necessary, to treat my condition, which has been explained to me as: _____

I understand that authorized, surgical product representatives may be present during my procedure to function in an advisory capacity **ONLY** under the direct supervision of a peri-operative registered nurse and/or operating practitioner.

Procedures to be performed: I understand the following surgical, medical and/or diagnostic procedures are planned for me, I understand the nature and the purpose of the procedures, and I voluntarily consent to and authorize these procedures:

I understand that my physician may discover other or different conditions, which require additional and/or different procedures than those planned. I authorize my physician and such associates, students, technical assistants and other health care providers to perform such other procedures, which are advisable in their professional judgments.

Use of Blood Products: I DO / DO NOT (circle one) consent to the administration of whole blood or packed red blood cells or any other blood component from approved blood banks. It has been explained to me that there is the possibility of ill effects including, but not limited to, infection and other disease resulting from the administration of blood or blood components. I acknowledge and agree that neither the physician nor the hospital, agents, or employees are responsible for any infectious disease or other complication with respect to the administration of blood or blood components. My doctor discussed the risks of blood transfusion with me, including the option of autologous for elective procedures.

Risks: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death. I also realize that the following risks and hazards may occur in connection with this particular procedure:

I am also aware of possible alternative modes of treatment, some of which include:

Photographs: Observers: I consent to the photographing and videotaping of the operations and procedures to be performed and to the presence of students or other observers in the operating room to observe the procedure for the purpose of advancing medical education. I am aware that only my physician may grant this permission on my consent. Any video/photographic documentation, if used would include appropriate portions of my body for medical, scientific, or educational purposes. In addition, the photographic documentation would be kept as part of the hospital record.

____ No medical student present for surgery.

____ I do consent / ____ I do not consent to allowing a qualified medical student, who is not a licensed provider, to perform important parts of the surgery which may include sensitive examinations, such as breast, pelvic, prostate, and rectal examinations. The qualified medical student will be performing only tasks that are within their scope of practice, as determined under State law and regulation and under the direct supervision and physical presence of a preceptor with appropriate privileges.

I have been given an opportunity to ask questions about my conditions, alternative forms of treatment, risks and benefits of the planned procedures, and risks/consequences of non-treatment. These questions have been answered to my satisfaction. I have sufficient information to give this informed consent. I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in and that I understand its contents.

Patient unable to sign this consent because: _____

Patient, parent, or Legal guardian Date Time Relationship to Patient

Witness to signature Date Time

I have assessed the patient, verified the procedure, and answered the patient's questions. The procedure is appropriate as planned.

Provider Signature Date Time

