CONSENT TO OPERATION, TREATMENT OR OTHER PROCEDURE

I hereby authorize Dr. _____ to perform upon _____ (patient)
the following operation, treatment, or other procedure: _____
_____
_____

My physician has explained the nature, advisability and purpose of the operation, treatment or other procedure, together with the benefits hoped to result; the risks and the possibility of complications; and alternatives to the operation, treatment or other procedure, if any, and the risks of such alternatives. I understand the explanations that have been given me and I understand that no guarantee is offered as to the results of the operation, treatment or other procedures.

1. I understand that some important surgical tasks may be performed by other doctors, assistant surgeons, providers or residents under the supervision of my doctor.
2. I authorize the physician to mark the correct surgical site with a temporary skin marker prior to the procedure.
3. I understand that during the course of the operation, treatment or other procedure unforeseen conditions may be found that make an extension of the original operation, treatment or other procedure advisable. I authorize and consent to such extension or other operation, treatment, or other procedure as is advisable in the professional judgment of my physician or physicians.
4. I authorize and consent to the disposal, use, retention or donation by the hospital, at its discretion, of all tissues, materials and substances that would normally be removed in the course of the operation, treatment or other procedure, excluding fetal remains/products of conception, as per the Fetal Specimen Disposal Policy.
5. I give my permission for observers to be present during my surgery or procedure for purposes of their medical training or for technical support.
6. I consent to the taking and reproduction of any photographs or video during this procedure for medical purposes.
7. Blood and Blood Products: I consent to the administration or transfusion of whole blood, packed red blood cells, plasma or platelets if I experience acute blood loss, acute or chronic anemia or other condition in which physician believes blood products are necessary. I understand there are no true alternatives to blood products that are capable of replacing the blood's ability to carry oxygen or to clot. My physician has described the risks, benefits and alternatives of this therapy. I understand that there are risks involved in receiving blood products even though precautions are taken and the blood and blood products I receive meet all state or federal requirements. These risks include fever, allergic reactions, and transmission of diseases such as hepatitis, HIV and cytomegalovirus (CMV). My doctor has discussed with me the risks of not consenting to receive blood or blood products.

If you do not consent to receive blood and blood products, initial here: _____

8. I hereby certify that I have read and fully understand the above Consent for Surgery and/or Special Procedures. I understand that I should not sign this form if all items have not been explained or answered to my satisfaction. I have been advised that if I desire further or more detailed explanation concerning my diagnosis, recommended and alternative procedures, or possible risks and consequences, it will be given to me by my physician. However, I am satisfied with the explanation given to me.

_____ _____ _____
Signature of person Performing Operation, Treatment, or Procedure: Date Time

_____ _____ _____
Signature of Patient or Legally Authorized Representative Date Time

_____ _____
Relationship of Representative Reason patient is unable to sign

_____ _____ _____
Signature of Witness Date Time

PATIENT LABEL

HAVASU REGIONAL MEDICAL CENTER

CONSENSU