**HOSPITAL**

# CONSENT TO SURGERY, ANESTHESIA, DIAGNOSTIC, AND THERAPEUTIC PROCEDURES

Patient's Name:_____

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I authorize and consent to the performance upon me of the following operation and/or procedure: (State name of operation and/or procedure in medical and lay terms, if necessary)_____

   _____

   _____

   _____

   to be performed by or under the direction of Dr. _____

2. It has been explained to me by my physician that, during the operation or procedure, unforeseen conditions may be revealed that necessitate an extension of the original operation or procedure, or different operation or procedure than those set forth in paragraph 1. I, therefore, consent and request that the above named physician perform such other operation(s) and/or procedure(s) that he/she considers necessary or advisable.
3. The nature and purpose of the proposed operation or procedure, attendant risks and possible discomforts involved, other methods of treatment, and the possibility of complications have been fully explained to me by my physician.
4. The proposed anesthetic(s), if any, alternative anesthetic(s), if any, and the benefits, risks, and possible discomforts associated with them have been explained to me by an anesthesiologist. I consent to the administration of such anesthetic(s).
5. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been given by anyone as to the results that may be obtained by the proposed operation and/or procedure.
6. I consent to the disposition by hospital authorities of any tissues, body parts, or products of conception that are removed, except as follows:_____
7. I consent to the administration of blood or blood products, including blood exchanges for infant(s), if applicable, as my physician shall deem necessary. The benefits, risks, and alternatives associated with the administration of blood or blood products have been explained to me by my physician.
8. I consent to the photographing of the operation or procedure to be performed for medical , scientific, or education purposes, provided that my identity is not revealed by the pictures or by descriptive texts accompanying them.
9. For the purposes of advancing medical education, I consent to the admittance of appropriate observers to the operation and/or procedure room.

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM, THAT THE EXPLANATIONS REFERRED TO WERE MADE, THAT I HAVE NO FURTHER QUESTIONS ABOUT THE TREATMENT TO BE GIVEN, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN OR STRICKEN BEFORE I SIGNED.**

_____
Patient's Signature

_____ _____
Witness Date Time a.m./p.m.)