The following procedure has been recommended to _____ (the patient) by his/her doctor(s).

Procedure _____

_____

_____

_____

1. I understand the risks and the alternatives of the Procedure, and voluntarily authorize and consent to its performance by Dr. _____, and/or such associates, assistants, technical, nursing and healthcare personnel as may be necessary. I understand all of the following:
   a. Practitioners other than the physician listed above may participate in my surgical/therapeutic/invasive procedure and permit and authorize other practitioners to perform other important aspects of the procedure(s) or significant surgical tasks.
   b. The identity of practitioners may not be known prior to the day or time of surgery, but the names of all practitioners who perform significant surgical tasks will be documented in my medical record.
   c. Generally, my (the patient's) physician, and his or her associates are not hospital employees or agents of the hospital.

2. I also authorize and consent to necessary and incidental procedures (such as radiology, pathology), and any additional or different procedures that may become necessary or advisable by my doctor(s) during the course of the Procedure.

3. I understand analgesia, anesthesia, or sedation may be necessary for the Procedure.

4. The presence of persons not directly involved in the performance of the Procedure may sometimes occur. I authorize and consent to the presence of observers authorized by my doctor(s) and anesthesiologist.
   Name (Company/Vendor) of observer: _____
   (Name to be added in operative record if not known at time of consent)

5. I also consent to photographing and videotaping the Procedure, and the publication of such photographs and videotapes for medical, scientific, or educational purposes provided my identity is not revealed. I agree that all such photographs and videotapes are and will remain the property of University Community Hospital or the Physician.

6. I understand that tissue, body parts, organs, or implantable devices may be removed during the Procedure. I authorize University Hospital and its personnel to handle and dispose of these in accordance with its usual policies and any applicable laws and regulations.

7. The nature and purpose of the Procedure, expected benefits, risks, discomforts and complications have been explained to me. The alternatives, including the consequences of not undergoing the Procedure, have also been explained to me.

8. I understand that no guarantees or assurances can be made, and none have been made to me by anyone regarding the results, success, outcome, or recovery from the Procedure, and that there is always the risk of serious complications or death. I understand that all surgical or invasive procedures and the recuperation from these procedures carry general risks such as blood loss, infection, allergic reactions and unplanned injuries to tissue, organs or nerves which may require corrective surgery.

9. I understand that the use of blood products or blood transfusions may become necessary in the event of an emergency. I may refuse consent for the use of blood products and human blood derived products by completing a separate form. ☐ Refuse Blood/Blood Products

10. The content of this form has been explained to me, I have read it or have had it read to me, and I have discussed the Procedure, purpose of the procedure, risks, benefits, alternatives and the likelihood of the procedure(s) achieving the treatment goals with my doctor.

11. All of my questions have been answered to my satisfaction. I hereby give my voluntary and informed consent to the performance of the proposed Procedure, and those procedures necessary or incidental to its performance, and accept the risks.

Witness	Date/Time	Patient/Legally Authorized Representative	Date/Time
Witness (Required for Telephone)	Date/Time	Relationship to Patient	

The Patient is unable to sign or give consent as reflected in the medical record because _____

ADDRESSOGRAPH

SURGERY/INVASIVE PROCEDURE CONSENT

Anesthesia care for this surgical procedure will be provided by a team consisting of Physician Anesthesiologists and supervised Certified Registered Nurse Anesthetists with special anesthesia training (the Anesthesia Care Team) whose names will be recorded on the operative record. I understand that the members of the Anesthesia Care Team are not employees or agents of University Hospital.

This anesthetic plan may include general ("asleep"), regional (epidural, spinal, nerve block), or monitored anesthesia care (MAC).

The intended anesthesia plan is: ☐ general ☐ regional ☐ MAC.
However, I understand that my condition may require that the anesthesiologist change the type of anesthetic given.

A member of the Anesthesia Care Team has explained to me the nature of my anesthesia plan, the way it will be given to me, the usual effects involved and medically acceptable alternatives. I understand that modern anesthesia is very safe, however, there can be risks and hazards regardless of the skill of the Anesthesia Care Team, which include but are not limited to: broken or dislodged teeth and or dental work, allergic reactions and other reactions, sore throat, awareness under anesthesia, inadequate pain control, hoarseness, pneumonia, inflammation of the veins, headache, lower back pain, nerve injury or paralysis, infection, damage to the heart, liver, lungs, kidneys, eyes, brain, and death.

I consent to the administration of necessary anesthesia by a member of the Anesthesia Care Team.

Witness	Date/Time	Patient or Legally Authorized Representative	Date/Time
Witness (Required for Telephone)	Date/Time	Relationship to Patient	

The Patient is unable to sign or give consent as reflected in the medical record because _____

SURGERY/INVASIVE PROCEDURE AFFIRMATION

Anesthesia signature represents affirmation that: A member of the Anesthesia Care Team has discussed the nature of the anesthesia care plan, the risks, benefits and alternatives with the patient/legally responsible person; and I acknowledge that the planned procedure and site are as stated in the consent. ☐ N/A

Anesthesia Signature: _____ Date: _____ Time: _____

Physician's signature represents affirmation that: I have discussed the nature of the procedure(s), the risks, benefits and alternatives of the planned procedure(s) with the patient/legally responsible person; and I agree with the planned procedure(s) and site(s) as stated in the consent.

Physician's Signature: _____ Date: _____ Time: _____

☐ If the physician administering sedation, signature also represents affirmation that:
I have discussed the nature of the sedation, the risks, benefits and alternatives with the patient; and I agree with the planned sedation as stated in the consent.

☐ **Safety process waived** (life/limb threatening emergency)

Physician's Signature: _____ Date: _____ Time: _____

DECLARATION OF EMERGENCY SITUATION

I have determined the patient is in a life/limb threatening situation and the proposed procedure is immediately medically necessary to ensure the life/health of the patient. The patient is unable to give consent and all reasonable attempts have been made to locate a legal representative. Any further delay in treatment will jeopardize the life/health of the patient.

Physician's Signature: _____ Date: _____ Time: _____

SURGERY/INVASIVE PROCEDURE CONSENT

University Hospital

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