University of Medical Center

CONSENT FOR SURGERY
AND OTHER PROCEDURES

1. I, ______________________ give permission to Dr. ______________________
   (myself or name of patient)
   his/her associates, and such assistants as may be selected to treat the following condition or conditions.

   ____
   (description of condition and need for treatment)

2. My healthcare provider has explained to my satisfaction the nature of the proposed procedure, surgery or treatment appropriate to treat my condition. I understand that the procedure, surgery, or treatment is:

   ____
   (state nature and extent of operation or procedure)

3. Site/Side of Operation: ______________________ ☐ Left ☐ Right ☐ N/A

4. I was told of reasonable alternatives to the proposed care, treatment and service. I was informed of the relevant risks, benefits, and side effects related to these alternatives, including the possible results of not receiving care, treatment, and service.

5. I was told that there is no sure way to know the result of the procedure, treatment or surgery. I was told of the potential risks or side effects listed below and of possible problems related to my recuperation.

MAJOR RISKS OF THE OPERATION OR PROCEDURE

____

____

____

6. During the operation, the healthcare provider may discover an UNEXPECTED, NON-EMERGENCY CONDITION OR DISEASE, which the healthcare provider thinks should be fixed during the operation. My signature on the line below gives my permission for the healthcare provider to use his own judgment in treating unexpected non-emergency conditions or diseases. ( ) **Not applicable**

   ____
   (Patient's or Consenting Adult's Signature - optional, not required)

7. I do not give permission to destroy or remove the following ORGANS, except as a life saving emergency procedure: ( ) **Not applicable**

   ____

8. I give permission to the University of Maryland Medical Center and its medical staff and the University of Maryland to throw away, use, and/or transfer for business reasons or for other reason any tissues taken from my body. These uses may include examination, education, research, other scientific reasons, and business deals. I give up any interest in or ownership of these tissues and anything developed from these tissues. ( ) **Not applicable**

9. MY SIGNATURE BELOW GIVES MY AGREEMENT
   (A) THAT I HAVE READ AND UNDERSTAND THIS CONSENT.
   (B) THAT I HAVE RECEIVED ALL OF THE INFORMATION I WANTED ABOUT THE OPERATION OR PROCEDURE, ITS BENEFITS, RISKS, COMPLICATIONS AND ALTERNATIVE TREATMENT CHOICES AND I HAD A CHANCE TO DISCUSS AND HAVE MY QUESTIONS CLARIFIED TO MY SATISFACTION BY THE HEALTHCARE PROVIDER.

Patient's or surrogate signature: ______________________

Witness: ______________________ Date: __________ Time: ________ am/pm

Signature of healthcare provider: ______________________ Date: __________ Time: ________ am/pm