CONSENT FOR DIAGNOSTIC PROCEDURE AND/OR TREATMENT

1. I, ______________________________(Patient's Name), authorize Dr.___________________________
or associates or assistants of his/her choice at the Hospital Center to perform upon me or the named patient the following procedure (please type or print and explain in non-technical language):

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including such photographing, videotaping, televising or other observation of the procedure(s) as may be purposeful for the advance of medical knowledge and/or education, with the understanding that my/the patient's identity will remain anonymous.

2. Dr ____has fully explained to me the nature and purpose of the procedure and has also informed me of the expected benefits and complications, attendant discomforts and risks that may arise (including the possibility of unknown risks associated with my undergoing this procedure), as well as possible alternatives to the proposed treatment, including no treatment. I have been given the opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

3. I understand that during the course of the procedure unforeseen conditions may arise which necessitate procedures different from those contemplated. I therefore consent to the performance of additional procedures which the above mentioned physician or his/her associates or assistants may consider necessary.

4. I understand that immediately prior to the procedure, anesthesia may be administered to me. Based upon the recommendation of my physician, I consent to the following:

   ☐ No anesthesia.

   ☐ Local or regional anesthesia to be administered by the treating physician or his/her designee. I understand that there is always the possibility that the local or regional anesthesia will need to be supplemented or replaced by general anesthesia, administered by an anesthesiologist.

   ☐ Conscious sedation administered by the treating physician. In conscious sedation, medications are administered that may cause complications such as breathing difficulties, drop in blood pressure and/or pulse.

   ☐ Anesthesia administered by an anesthesiologist (requires a separate Consent for Anesthesia). The alternatives, risks, benefits, and complications of the anesthesia options have been explained to me.

5. Any tissue removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues may be disposed of in accordance with accustomed practice.

6. I acknowledge that no guarantees or assurances have been made to me concerning the result intended from the procedure.

7. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.

______________________________	______________________________
Signature of Interpreter (if required)	Signature of Patient or Legally Authorized Representative
______________________________	______________________________
Print Name of Interpreter	Print Name of Patient/Authorized Representative
	______________________________
Date______________________	Relationship, if signed by person other than patient
	**Witness______________________
	Signature of Witness
	______________________________
	Print Name of Witness

* the signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or otherwise lacks capacity to consent.

** Witness's role is to verify patient's signature only.

If a transfusion of blood or blood products is anticipated or may be needed during the procedure (including the duration of loss of capacity to consent due to the anesthesia given), a Consent for Blood Transfusion should also be obtained.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure, have offered to answer any questions and have fully answered such questions. I believe that the patient/legally authorized representative fully understands what I have explained and answered.

Date:__________________

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Physician's Signature