CONSENT FOR OPERATIVE, OTHER INVASIVE & NON-INVASIVE PROCEDURES

Prior to undergoing a procedure, you should understand from your doctor the risks and benefits and potential complications of the procedure, the alternatives to having the procedure done, and have had the opportunity to have your questions answered. This form simply confirms that this discussion has occurred and that you have already consented to the procedure.

1. I consent to the performance upon _____ (myself or name of patient) of the following operation(s) and/or procedure(s): state name of operation(s) and/or procedure(s) in medical and lay terms, if necessary,

   _____

   by or under the supervision of the physician, Dr.(s) _____

2. I understand that during the operation(s) or procedure(s) unforeseen conditions may be discovered which may result in an extension of the original operation(s), or different operation(s) or procedure(s) than those set forth in paragraph 1. I consent to such other operation(s) and/or procedure(s) which the physician then considers necessary or advisable, except for _____ (note any excluded additional procedures).

3. I understand the nature and purpose of the proposed operation(s) or procedure(s), the prognosis of my medical condition with and without the proposed intervention, the risks and possible discomforts involved, other effective methods of treatment (if any), and the possibilities of complications.

4. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been given by anyone as to the results that may occur from the proposed operation(s) and/or procedure(s).

5. I understand the proposed anesthetic(s), if any, including the possibility of the administration of conscious sedation, alternative anesthetic(s), if any, and the risks and possible discomforts associated with them. I understand that all forms of anesthesia involve some risks, and no guarantees or promises can be made concerning the results of my anesthetic. Although rare, unexpected severe complications with anesthesia can occur. Sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used, including general anesthesia. I understand that appropriate anesthetic management may include intravenous access, endotracheal intubation, mechanical ventilation or the use of drugs that stimulate the cardiovascular system. If DNR (Do Not Resuscitate) orders are currently in effect I understand that I would not receive closed chest massage, electrical defibrillation or external cardiac pacing in the event of a cardiac arrest.

6. I understand that potential risks associated with an infusion of blood may include transfusion reactions and transmission of infectious diseases, including, but not limited to, hepatitis and HIV (the "AIDS" virus). Although all blood units that I may receive will have been subjected to a variety of standardized and recognized laboratory tests, it is possible that a very small percentage of units may still be infected. I understand that the alternatives to receiving blood and/or blood components include autologous donations, directed donations and not receiving blood or blood components. I consent to the infusion of blood or blood products, including blood exchanges for infant(s), if applicable, as the physician shall deem necessary, except for _____ (note any exclusions).

7. I consent to the disposal by the Hospital of any tissues, body parts, or products of conception which are removed, including their possible donation, without patient identifying information, to third parties for research purposes (from which neither the Hospital, the members of its medical staff, nor I will derive financial benefit), except as follows:

   _____

8. I consent to the photographing or closed circuit television of the operation(s) or procedure(s) to be performed, including appropriate portions of the body, for medical, scientific or educational purposes, provided that my identity is not revealed by the pictures or by descriptive texts accompanying them.

9. For the purpose of advancing medical education, I consent to observers in the operating and/or procedure room.

10. I understand that various assistants may be used during my operation(s) and/or procedure(s) and that some of those assistants may be in the hospital training programs.

11. Additional comments/directions (if any): _____

_____

If items 1-7 are deleted or changed, the Physician and Department Director must be notified prior to the operation or procedure.

I certify that I have read and fully understand this consent form, that I have no further questions about the treatment to be given, and that all blanks or statements requiring completion were filled in or stricken before I signed.

SIGNATURE WITNESSED BY:

_____
Signature line

_____
Print or type name here

Address: _____

_____

SIGNED BY PATIENT/SURROGATE

_____
Signature line

_____
Print or type name here

Date: _____ time _____ am/pm

If the patient is a minor, incompetent, or unable to give consent, complete the following:

I further certify that the patient is unable to give consent because _____

_____ and

that I am authorized to consent for him/her because _____

_____.

Signature witness by:

_____

_____
Print or type name here

Date: _____ time _____ am/pm

Signed by:

_____

_____
Print or type name here

Address: _____

_____

Telephone #: _____

PHYSICIAN'S CONFIRMATION OF INFORMED CONSENT

I certify that I explained to the patient (or legally responsible agent) his/her condition, the proposed operation(s) or procedure(s), attendant risks and possible discomforts involved, other methods of treatment, the potential results of nontreatment and the possibility of complications, prior to the performance of the proposed operation(s) or procedure(s).

_____
Physician's Signature / Date

_____
Print or type name here

ANESTHESIOLOGIST'S CONFIRMATION OF INFORMED CONSENT
(if applicable)

I certify that I explained to the patient (or legally responsible agent) the proposed anesthetic(s), alternative anesthetic(s), if any, and the risks and possible discomforts associated with them, prior to the performance of the proposed operation(s) or procedure(s).

_____
Anesthesiologist's signature / Date

_____
Print or type name here