INFORMED CONSENT TO OPERATION/PROCEDURE,
MEDICAL TREATMENT AND ANESTHESIA

(1) I hereby authorize Dr.______________________
and associate or assistant _____________________involved
in my care to perform procedure(s) planned for treatment of my
condition.

(2) The procedure(s) planned for treatment of my condition
has (have) been explained to me by my physician as
Follows:

PROCEDURE (S)
___________________________________________
_____________________________
_____________________________
____________________________________________
(3) I recognize that, during the course of the operation, post
operative care, medical treatment, anesthesia, or other
procedure, unforeseen conditions may necessitate my above-
named physician and his or her assistants, to perform such
additional surgical or other procedures as are necessary.

(4) I have been informed that there are many significant risks,
such as severe loss of blood, infection, cardiac arrest and
other consequences that can lead to death or permanent or
partial disability, which can result from any procedure.
Risks specific to this procedure:

___________________________________________
____________________________________________
____________________________________________
(5) No promise or guarantee has been made to me as to result or cure.

(6) I consent to the administration of (general, spinal, regional,
conscious sedation, local) anesthesia by my attending physician,
by an anesthesiologist, a nurse anesthetist, or other qualified parties
under the direction of a physician as may be deemed necessary.
I understand that my anesthesia practitioner will discuss anesthesia
risks and benefits to me prior to the procedure.

ALL SECTIONS THAT APPLY BELOW MUST BE
INITIALED BY PATIENT

(7) I consent to the observation of the operative
procedure for the purpose of advancing medical education.

(8) Any tissues or part surgically removed may be
disposed of by the hospital or physician in accordance with
custom/legal practice.

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

(10) I consent to vendor presence in the operating
room when deemed necessary.

(11) In the event of surgical participants’ needle
and blade injury, I authorize my blood drawn for HIV and
Hepatitis screening.

(12) I understand that tissue products may include
donated human tissue (skin for example), products made
from human tissues and other items which contain animal
parts. One or more of the same or similar products may be
implanted into my body during surgery if needed.

Any additional comments, complications, other planned
procedures, and other surgeon’s names may be inserted
here:

___________________________________________
____________________________________________
____________________________________________

PATIENT INITIALS

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FULL DISCLOSURE

I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

A) Diagnosis or probable diagnosis  
B) Nature of treatment or procedures recommended  
C) Risks or complications involved in such treatment or procedures  
D) Alternative forms of treatment, including non-treatment, available are described below:

E) Anticipated results of the treatment.

F) Possible circumstances under which information about me must, by law/regulation, be disclosed or reported such as diagnosis of specific communicable diseases.

I have the opportunity to ask questions about this procedure and they have been answered to my satisfaction.

Patient/other Legally Responsible Person  Professional Witness  Date  Time

Relationship if Applicable Signature

I have fully explained to the patient or patient’s authorized representative the nature of the procedure, the risks, possible complications and expected benefits or the effects of the procedure and any other alternatives to the treatment and their risks and benefits.

__________________________  ____________________  ___________________
Physician’s Signature        Date                     Time

Physician's Printed Name

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PRE-PROCEDURE TIME OUT BEDSIDE PROCEDURES

Patient’s name and date of birth match wristband and consent form.

Intended procedure matches consent form.

Intended side/site identified, and matches consent form if applicable.

__________________________  ____________________  ___________________
Signature of Individual Documenting Time Out        Date                     Time

(Completed by person other than one performing procedure)