

1. I hereby authorize Dr. \_\_\_\_\_ and/or such assistants or associates selected by him/her to perform on (patient name) \_\_\_\_\_ the following procedure(s);  
\_\_\_\_\_
2. The procedure(s) necessary to treat my condition has/have been explained to me by Dr. \_\_\_\_\_ and I understand the nature of the procedure to be: (describe the procedure(s) in language which the patient can understand)  
\_\_\_\_\_  
\_\_\_\_\_
3. If during the course of these procedures the discovery of unforeseen conditions requires in the judgement of the persons described above, different procedures than those planned, I authorize such different procedures as are deemed appropriate.
4. I have been informed of the benefits as well as alternative methods of treatment and risks for the procedure described above. I have also been informed that in the performance of surgical procedures there is a potential for certain complications including but not limited to infection, allergic reaction, blood clots in veins, arteries, and lungs, hemorrhage and damage to adjacent vessels and organs which may require repair or removal during the procedure or an additional return to surgery, stroke, heart attack and death.  
\_\_\_\_\_  
\_\_\_\_\_
5. I understand that a **Transfusion of Blood or Blood Products** may be necessary and as with any treatment there is a possibility of unwanted effects or side effects. These possibilities include, but are not limited to, certain allergic reactions that might produce a skin rash or fever or other transfusion reactions. Despite the fact that extreme precautions are taken, certain infections may be passed on through a transfusion. These include, but are not limited to, the viruses that cause hepatitis and in extremely rare instances the virus that causes Acquired Immune Deficiency Syndrome (**AIDS**) which is called Human Immunodeficiency Virus (**HIV**). The blood has been tested by the blood bank for **AIDS** and **Hepatitis B**.
6. I understand that during this procedure, photographs, slides, videotape or motion pictures may be taken for documentation and/or teaching purposes, and consent to the taking of such pictures and their use for the stated purpose.
7. I consent to the Hospital's disposal of any tissues, parts, organs, or extremities which may be removed as a result of the procedure(s) authorized above.
8. **I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.**

\_\_\_\_\_  
Patient Signature Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
Authorized Person Signature Relationship \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_  
Witness Signature Date \_\_\_\_\_ Time \_\_\_\_\_

Telephone Consent By: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature Witness Signature \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, I explained to the (above patient) (person authorized to consent for the above patient) the nature of the condition(s) which appear indicated by diagnostic study, and advised the patient of possible risks, hazards, complications and consequences which are or may be associated with the operation(s). The patient or other individual whose signature is shown above has indicated his or her understanding, has consented to the performance thereof, and has stated that no further explanation was desired.

\_\_\_\_\_  
Physician Signature Date \_\_\_\_\_ Time \_\_\_\_\_



Patient Identification

**CONSENT FOR OPERATION**