# Consent for Surgery or Other Medical Procedure

By signing this form, I agree and consent to the procedures listed here **(Laterality must be indicated when applicable):** _____

_____

_____

_____

_____

To be performed by: _____

I understand and agree to the following items:

1. **CONSENT:** My Physician or Advanced Practice Provider (APP) may have his/her qualified associates and/or assistants perform a portion of my procedure.
2. **OBSERVERS:** Under the direct supervision of my healthcare Physician or APP, approved observers, including but not limited to visiting Physician or APPs, students, pharmacy personnel and vendors, may witness and support the procedure for treatment or health care operations purposes, including education. They are obligated to protect my privacy in accordance with the HIPAA Rules.
3. **ADDITIONAL PROCEDURES:** Extensions, revisions, or procedures in addition to or different from those listed above that are reasonably necessary to address unanticipated conditions discovered during the procedure may be performed when medically necessary, based on the professional medical opinion of my Physician or APP.
4. **RISKS & ALTERNATIVES:** I have been advised by my Physician or APP of the risks and non-surgical alternatives of the procedure and acknowledge that no guarantee has been made to me regarding the outcome. I have been informed that there are risks associated with the performance of any surgical procedure, including but not limited to, severe loss of blood, infection, cardiac arrest, complete or partial paralysis, brain damage, and others, including death.
5. **MEDICATIONS:** I consent to procedural sedation, anesthetics or medications other than those provided by my anesthesiologist on the recommendation and guidance of my Physician or APP. Although unusual, severe and unexpected complications can occur, including the possibility of infection, bleeding, drug reactions, blood clots, stroke, nerve injury, heart attack or death. Other risks include damage or failure of liver, kidneys, brain, lung and heart. My Physician or APP has discussed medications that may be used during the procedure.
6. **IMAGES:** I agree that the hospital may create photography and/or videography in the course of the performance of my procedure, which may be used for treatment or other permitted purposes. Images will be de-identified to the extent possible or I may be asked to sign a separate authorization for the use or disclosure as required by the HIPAA Rules.
7. **DISPOSAL OF TISSUES AND MATERIALS:** I understand that, unless I instruct the hospital otherwise, all tissues, surgical specimens and materials removed during my surgery will be disposed of by the hospital in accordance with customary hospital procedures.
8. **PATIENTS OF CHILD BEARING AGE:** I understand that undergoing surgery or anesthesia, or exposure to radiation or x-ray while pregnant, may result in miscarriage or harmful effects to an unborn child. My Physician or APP has discussed these risks with me.
9. **BLOOD PRODUCTS:** I agree to receive blood products immediately before, during or after my surgery if the treating Physician/APP thinks my condition requires it. The risks, possible alternatives, and potential complications of receiving blood and/or blood products, including a transfusion reaction and infectious complications, have been discussed with me. If I disagree with accepting blood or blood products, I have informed my physician.
   - ☐ I REFUSE blood products _____ (patient initials)
10. **SENSITIVE EXAMS:** I understand that this Hospital is a training facility for medical students, residents, fellows, nurses, etc. ("Learners"). I understand that those Learners are educated through supervised performance of procedures/exams. If a Sensitive Exam (an exam of the pelvic, urogenital, prostate or rectal areas), is a routine and medically necessary part of my procedure:
    - I have been informed a Sensitive Exam is a medically necessary part of my procedure and will be performed under anesthesia. I agree and consent to a Learner performing the Sensitive Exam. _____ (patient initials)
    - I understand that if I do not initial above to allow a Learner to perform the Sensitive Exam, it will be performed by my Physician or APP.
11. **DO NOT RESUSCITATE (DNR):** If I have signed a request not to be resuscitated in case of cardiac arrest during my hospital stay, my options are below. I understand that failure to select an option may result in temporary suspension of DNR during anesthesia.
    - ☐ Not Applicable: I do not have a DNR order.
    - ☐ PAUSE my DNR: I want my DNR paused during my surgery and recovery. If my heart stops, the medical team WILL try to revive me. My DNR will go back into effect once I recover from anesthesia.
    - ☐ KEEP my DNR Active: I do NOT want my DNR paused. If my heart stops, the medical team will NOT try to revive me. (Note: You must discuss this with your surgeon or anesthesiologist before your procedure).

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**I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I have reviewed this form and give permission for the procedure, intervention, or treatment, according to the terms described in this form.**

CONSENT

_____/_____/_____
Signature of Patient/Surrogate Date Time

_____
PRINTED NAME and Relationship, if signed by surrogate (or by phone)

Telephone or Verbal Consent ONLY

_____/_____/_____
Signature of Witness #1 (Physician or Nurse) Date Time

_____/_____/_____
Signature of Witness #2 (Physician or Nurse) Date Time

If an interpreter was used for obtaining this consent please provide the following information.

Interpreter Name: _____

Interpreter ID Number: _____

PHYSICIAN/APP CONSENT STATEMENT
I have discussed with the patient the potential benefits, risks, and side effects of receiving the proposed care, treatment and services (which includes but is not limited to administration of medications, interventions, and/or procedures). Additionally discussed and explained were the possible risks and benefits of reasonable alternatives to proposed care and treatment, including the risks of receiving no care, complications, the likelihood of the patient achieving his or her goals of treatment, and the anticipated recuperation and any potential problems that might occur during recuperation. The patient and/or their representative(s) have been provided the opportunity to ask questions, have their questions answered and have verbalized they wish to proceed with proposed care, treatment, and services.

Physician/APP Signature Printed Name Date Time

Resident Physician Signature (Optional)

Physician/APP Signature Printed Name Date Time