Patient Name: _____ Date of birth:_____

I hereby authorize Dr._____ and associates or assistants selected by this physician to treat the following condition(s) which has (have) been explained to me:

_____

The procedures planned for treatment of my condition(s) have been explained to me by my physician. I understand them to be:

_____

_____

I have been informed of and understand the expected result of the treatment listed above. I know that during anesthesia, the operation, the procedure, or follow-up treatment, unexpected conditions may require additional treatment. I agree that my physician and his or her assistants or designees may perform other necessary treatment in my best interest.

I have been informed that there are significant risks related to this procedure, such as blood loss, infection, and cardiac arrest that could lead to death or permanent disability. No promise or guarantee has been made to me about the result of this treatment.

I have been informed of the risks and benefits of not doing the procedure or treatment. I have been informed of other forms of treatment available to me, and their associated risks and benefits.

CROSS OUT ANY SECTIONS BELOW THAT DO NOT APPLY.

Both physician and patient should initial the crossed out section.

ANESTHESIA: General anesthesia, regional anesthesia, or sedation may be given to me by my attending physician, an anesthesiologist, or other qualified person as needed. I understand that there are risks related to anesthesia, such as damage to vital organs, paralysis, cardiac arrest or brain death from known and unknown causes.

TRANSFUSION OF BLOOD OR BLOOD COMPONENTS: I have been informed of the risks, benefits, and alternatives to transfusion of blood components. I understand these risks to include infection, transfusion reaction, and death.

I consent to the transfusion of blood components as considered necessary. I understand that this consent is valid for the duration of my hospital stay, and I can revoke my consent for blood transfusion at any time.

TISSUE: Any tissue removed may be disposed of by the hospital or physician by appropriate procedure.

☐ I prefer not to be informed of the treatment or procedure, and any risks, benefits, or alternatives.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME. I HAVE READ IT OR HAD IT READ TO ME, AND HAVE HAD THE OPPORTUNITY TO HAVE QUESTIONS ANSWERED. THE SPACES HAVE BEEN FILLED IN AND I UNDERSTAND ITS CONTENTS.

_____ _____ _____

Physician signature verifying procedure **Date** **Time**

__Physician requests RN witness to patient signature

_____ _____ _____

Patient/Responsible Person and relationship to patient **Date** **Time**

_____ _____ _____

Nurse witness to patient signature (optional) **Date** **Time**