Surgery and Procedure Consent Form

You have the right and responsibility to make decision concerning your healthcare. Your physician will provide you with all the information you need to help you make the best decision for you. As a member of the healthcare team, it is important that you are a participant in the decision making process. The completion of this form serves as your informed consent to the surgery or procedure that you have discussed at length with your physician.

1. I hereby authorize Dr. _____ and/or assistants selected by this physician physician to perform the following surgery or procedure(s): _____ _____

2. In the event that other conditions become apparent during anesthesia, sedation or during the surgical process, I authorize the above physical/assistant to exercise their judgment in attending to these conditions. This authority extends to treating conditions that were not previously known or forseen.

3. My physician/Assistant has full informed me and I understand the following:
    a. The benefits, risks, and complications of this specific surgery or procedure.
    b. There are significant risks such as blood loss, damage to surrounding organs, tissues, vessels, infection. These risks may be cause for a return to surgery or cardiac arrest. I understand that cardiac arrest may result from the performance of any surgery or procedure(s) and could lead to partial or permanent or death. My physician also explained the following additional risks which are not limited to:

        _____

        _____

        _____

    c. No guarantee has been made to me in regards to result or cure.
    d. All medically acceptable alternative or therapies and the benefits, risks, and complications of those alternatives and therapies.
    e. I have the right to refuse the recommended surgery or procedure(s), My options will be made available to me if I refuse to consent. I have been informed of the expected consequences should I refuse the recommended surgery or procedure.

4. I consent to the administration of anesthesia or sedation by the physician, an anesthesiologist, or other qualified party under the direction of a physician as may be necessary. I understand the possible risks, complications (including death), and damage to vital organs that could occur under anesthesia or sedation.

5. Any removed tissue, organs, body parts, or fluids will be disposed of in accordance with this medical facility's policies, however, I understand that these may be used for diagnosis of the medical condition, for study and medical research, or for the general advancement of medical knowledge

6. I acknowledge that among those who attend to patients at Family Medicine, are students and other observers and they may be present during the medical or surgical procedure(s) for educational purposes.

7. I authorize the physician and Family Medicine to photograph/videotape my surgery for procedure(s) at his/her discretion. I understand the photograph(s)/videotape will be used only for the purpose of medical study, research and/or for documentation for the medical record.

8. FOR THE PATIENT WITH A DO NOT RESUSCITATE ORDER:
I understand that the DO Not Resuscitate Order shall be rescinded for the duration of surgery or procedure(s) and recovery.

FOR EXCEPTION: _____ (Patient or Guardian Initials) *I want the Do Not Resuscitate Order kept in effect during the surgery or procedure(s) and recovery. I understand that I need to discuss this request with the physician.*

I have had sufficient opportunity to discuss the medical condition and the planned surgery or procedure(s) and anesthesia sedation with the above named physician and/or associate and all of my questions have been answered to my satisfaction. I understand all contents of this form, the medical condition, and the planned surgery or procedure(s) and I have adequate information upon which to base an informed consent.

Patient/Legally Authorized Guardian Signature

_____ Patient Signature	_____ Patient Printed Name
_____ Legally Authorized Guardian Signature	_____ Legally Authorized Guardian Printed Name
_____ Witness To Signature	_____ Witness Printed Name
_____ Second Witness For Phone Consent	
_____ Interpreter	_____ Language Interpreted

Patient unable to sign because: _____

Administrative Authorization: *Only for incompetent patient with no Legally Authorized Guardian*

_____ Administration Signature	_____ Date	____:_____ AM PM Time

Physician Informant

_____/_____ Physician Authentication	ID#	_____ Date	____:_____ AM PM Time