INFORMED CONSENT TO SURGERY OR SPECIAL PROCEDURE

1. This form is called an "informed Consent form." It is your doctor's obligation to provide you with the information you need in order to decide whether to consent to the surgery or special procedure that your doctors have recommended. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you. You should read this form carefully and ask questions of your doctors so that you understand the operation or procedure before you decide whether or not to give your consent. If you have questions, you are encouraged and expected to ask them before you sign this form. Your doctors are not employees or agents of the facility. They are independent medical practitioners.

2. Your doctors have recommended the following operation or procedure:

_____

_____

and the following type of anesthesia: [ ] Local [ ] IV Sedation [ ]MAC [ ]General

Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the doctor(s) performing the procedure, may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the doctor named below (or, in the event the doctor is unable to perform or complete the procedure, a qualified substitute doctor), together with associates and assistants, including anesthesiologists, pathologists, and radiologists from the medical staff of this facility to whom the doctor(s) performing the procedure may assign designated responsibilities.

3. Name of the practitioner who is performing the procedure or administering the medical treatment: _____

The facility maintains personnel and facilities to assist your doctors in their performance of various surgical operations and other special diagnostic or therapeutic procedures. However, your doctors, surgeons and the persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology, or pathology are not employees or agents of the facility or of doctor(s) performing the procedure. They are independent medical practitioners.

4. All operations and procedures carry the risk of unsuccessful results, complications, injury or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of:

- The nature of the operation or procedure, including other care, treatment or medications;
- Potential benefits, risks or side effects of the operation or procedure, including potential problems that might occur with the anesthesia to be used and during recuperation;
- the likelihood of achieving treatment goals;

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▪ Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment; and

▪ Any independent medical research or significant economic interests your doctor may have related to the performance of the proposed operation or procedure.

Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to give or refuse consent to any proposed operation or procedure at any time prior to its performance.

5. By your signature below, you authorize the pathologist to use his or her discretion in disposition or use of any member, organ or tissue removed from your person during the operation or procedure set forth above, subject to the following conditions (if any):

_____

6. Your doctor will discuss with you the risks and benefits of the recommended operation or procedure, including the following (the patient's doctor is responsible for the content of the information provided below):

a. The nature of the operation or procedure and the anesthesia, including the surgical site and laterality if applicable: _____

_____

b. The expected benefits or effects of the operation or procedure and anesthesia:

_____

_____

c. The possible risks and/or complications of the operation or procedure and anesthesia, including potential problems that might occur during recuperation include, but are not limited to: _____

_____

d. Due to the following specific medical condition(s):

_____

additional risks and/or complications of the operation or procedure and anesthesia include, but are not limited to:

_____

_____

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e. Alternative methods of treatment, including the nature of such treatments, their expected benefits or effects, and their possible risks and complications include:

_____

_____

f. Other issues discussed with the patient:

_____

_____

8. Your signature on this form indicates that:

- you have read and understand the information provided in this form;
- your doctor has adequately explained to you the operation or procedure and the anesthesia set forth above, along with the risks, benefits, and the other information described above in this form;
- you have had a chance to ask your doctors questions;
- you have received all of the information you desire concerning the operation or procedure and the anesthesia; and
- you authorize and consent to the performance of the operation or procedure and the anesthesia.
-

_____ _____

(date) *(time)*

[ ] By Checking this Box I acknowledge that I consent to having this operation or procedure and to have Electronically Signed this Document

Patient's Name: _____

[ ] By Checking this Box I acknowledge that I am the authorized delegate for the patient and I have Electronically Signed this Document.

Authorized Delegate Name: _____

[ ] By Checking this Box I acknowledge that I am a witness to Electronic Signing of the document.

:

Witness Name:_____

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PHYSICIAN CERTIFICATION

I, the undersigned physician, hereby certify that i have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including:

- the risks and benefits of the procedure;
- any adverse reactions that may reasonably be expected to occur;
- any alternative efficacious methods of treatment which may be medically viable;
- the potential problems that may occur during recuperation; and
- any research or economic interest i may have regarding this treatment.

I further certify that the patient was encouraged to ask questions and that all questions were answered.

_____ _____

(*date)* *(time)*

[ ] By Checking this Box I acknowledge that I am the Physician and have Electronically Signed this Document

Physician's Name: _____

INTERPRETER'S STATEMENT

I have accurately and completely read the foregoing document to (patient or patient's legal representative) in the patient's or legal representative's primary language:(identify language) _____ He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

_____ _____

(date) *(time)*

[ ] By Checking this Box I acknowledge that I am the Interpreter and have Electronically Signed this Document

Interpreter's Name: _____