AUTHORIZATION TO SURGERY OR SPECIAL PROCEDURE

I. You are scheduled for the following operation or procedure: _____

_____

_____

_____

_____

_____

_____

Anesthesia will be administered as recommended by your practitioner/anesthesiologist. 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 (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 Dameron Hospital, to whom the doctor(s) performing the procedure may assign designated responsibilities. The hospital maintains personnel and facilities to assist your doctors in their performance of various surgical operations and other special diagnostic or therapeutic procedures. However, 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 hospital or of doctor(s) performing the procedure. They are independent medical practitioners.

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

_____

III. 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:

1. The nature of the operation or procedure, including other care, treatment or medications;
2. Potential benefits, risks or side effects of the operation or procedure, including potential problems that might occur during recuperation;
3. The likelihood of achieving treatment goals;
4. Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment;
5. 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.

IV. If your doctor determines that there is a reasonable possibility that you may need a blood transfusion as a result of the surgery or procedure to which you are consenting, your doctor will inform you of this and will provide you with information concerning the benefits and risks of the various options for blood transfusion, including predonation by yourself or others. You also have the right to have adequate time before your procedure to arrange for predonation, but you can waive this right if you do not wish to wait. Transfusion of blood or blood products involves certain risks, including the transmission of disease such as hepatitis or Human Immunodeficiency Virus (HIV) and you have a right to consent or refuse consent to any transfusion. You should discuss any questions that you may have about transfusions with your doctor.

V. 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.

VI. Your signature on this form indicates that:

1. You have read and understand the information provided in this form;
2. Your doctor has adequately explained to you the operation or procedure and the anesthesia set forth above, along with the risks, benefits, and alternatives, and the other information described above in this form;
3. You have had a chance to ask your doctors questions;
4. You have received all of the information you desire concerning the operation or procedure and the anesthesia;
5. You authorized and consent to the performance of the operation or procedure and the anesthesia; and
6. You authorize the use of your Social Security Number for tracking purposes (Safe Medical Act of 1993), if you are receiving an implantable device.

Date_____ Time _____ am/pm

Signature_____
(Patient/parent/conservator/guardian)
If signed by other than patient, indicate name and relationship: _____

Witness: _____ Name: _____
(Signature) *(Print)*

Physician Certification Of Informed Consent

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:

1. The risks and benefits of the procedure;
2. Any adverse reactions that may reasonably be expected to occur;
3. Any alternative efficacious methods of treatment which may be medically-viable;
4. The potential problems that may occur during recuperation; and
5. Any research or economic interest I may have regarding this treatment.

I understand that the content of this Authorization is correct. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Date_____ Time _____ am/pm

Signature: _____ Name: _____
(Signature) *(Print)*

☐ *Not Applicable*

Consent to Blood Transfusion

Your signature below indicates that;

1. You have received a copy of the brochure, A Patient's Guide to Blood Transfusions.
2. You have received information from your doctor concerning the risks and benefits of blood transfusion and of any alternative therapies and their risks and benefits.
3. You have had the opportunity to discuss this matter with your doctor, including pre-operative predonation.
4. Subject to any special instructions listed below, you consent to such blood transfusion as your doctor may order in connection with the operation or procedure described in this consent form.

Special Instructions:_____

_____

(Clinical staff to list above any specific instructions for patient's blood transfusion, e.g., predonation, direct donation, etc.)

Date_____ Time _____ am/pm

Signature_____
(Patient/parent/conservator/guardian)

If signed by other than patient, indicate name and relationship: _____

Witness: _____ Name: _____
(Signature) *(Print)*

☐ *Not Applicable*

Interpreter's Statement

This authorization for consent(s) has been read by Interpreter Services to the patient or patient's legal representative_____ in the patient's or patient's legal representative's primary language_____. He/she understood all of the terms and conditions and acknowledged his/her agreement by signing this document.

Date: _____ Time:_____ am/pm

Interpreter name: _____ Agency: _____

Arrangement made by (employee signature) _____