CONSENT FOR SURGERY / PROCEDURE / TREATMENT

I hereby authorize __________________________ (licensed provider) to perform the following surgery/procedure/treatment:

__________________________

and the assistant(s) __________________________ (which he/she may select for the purpose of performing the following significant medical/surgical tasks as part of the surgery/procedure/treatment.

I understand that Saint Francis Hospital and Medical Center is a graduate medical education teaching site and that interns, residents, and/or medical students may also be in attendance and/or assisting in the performance of the above specified surgery/procedure/treatment. In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above surgery/procedure/treatment that require the assistance of other qualified medical personnel who have not been identified.

I have had explained to me in connection with the proposed surgery/procedure/treatment: (i) the nature and purpose of the proposed surgery/procedure/treatment; (ii) the material risks and consequences of the proposed surgery/procedure/treatment, including the risk that the proposed surgery/procedure/treatment may not achieve the desired objective, and the reasonable risks, including adverse reactions to implants and wound closure materials; (iii) the alternatives to the proposed surgery/procedure/treatment and the associated risks and anticipated benefits to such alternatives; and (iv) the material risks to the transfusion of blood and blood products should I need a transfusion that include, but are not necessarily limited to: fever, an allergic reaction, hepatitis or other infections, and human immunodeficiency virus (HIV). I authorize the administration of blood or blood products to me if it is medically necessary, unless other stipulated on a separate informed refusal for blood transfusion.

☐ Refuse transfusion of blood/blood products (reason).

In obtaining my informed consent to the surgery/procedure/treatment, I have been informed of the following reasonably foreseeable risks:

__________________________

I understand that the following alternatives exist for treatment:

__________________________

I am aware that, in addition to the foreseeable material risks described above, that there are other foreseeable material risks, such as death, which have been discussed with me, but are not listed above. I affirm that I understand the purpose and potential benefits of the proposed surgery/procedure/treatment, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed surgery/procedure/treatment and any alternatives. I understand that unforeseen circumstances may arise during the course of a procedure which may require other or additional operative or medical procedures. I authorize the physician(s) named above and his/her assistant(s) to modify the proposed procedure or to perform any added procedures as are necessary or advisable in the exercise of professional judgment.

I also authorize Saint Francis Hospital and Medical Center and the above-name physician(s) to observe, record, photograph, video and/or use any other mediums which result in the documentation of my image for medical, scientific, or educational purposes, provided my identity is not revealed by them. I understand that I have the right to refuse such observation, recording, photographing or videotaping. My decision will not influence the choice of operation/procedure or the way in which it is performed. I understand that the quality of care I receive at this hospital will not be affected in any way if I decide not to participate.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

__________________________ / __________ / __________
Patient or Legally Authorized Representative (Signature) Date Time

__________________________ / __________ / __________
Licensed Practitioner (Signature) Date Time

Interpreter responsible for explaining procedures and special treatment:

__________________________

EMERGENCY PROCEDURE / PATIENT UNABLE TO SIGN (Reason)

__________________________ / __________ / __________
Licensed Practitioner (Signature) Date Time

__________________________ / __________ / __________
Witness (Signature) Date Time