



01-50118

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CONSENT FOR OPERATIVE OR PROCEDURAL INTERVENTION

Patient Name: _____

PART I: PROPOSAL FOR OPERATIVE OR PROCEDURAL INTERVENTION

As the physician(s) responsible for the care of the above named patient. I/We Dr.(s) _____ proposes to perform the following operation or procedure:

A) IDENTIFICATION OF OPERATION OR PROCEDURE (in scientific language and layman description):

B) PHYSICIAN OR DESIGNEE CERTIFICATION: I, _____, have counseled this patient as to the nature of the procedure which I have proposed. I have specifically discussed the significant risks of this procedure; the nature and purpose of this procedure; the possible alternative methods of treatment and the relevant risks, benefits and side effects related to alternatives, including the possible results of not receiving care, treatment and services. In proposing this treatment, I have told this patient that it is my opinion based upon my knowledge of the case and upon my training and experience, that the potential benefits of this procedure outweigh the potential risks, but I have also acknowledged that other opinions may exist and that the patient should obtain a "second opinion" if he/she so desires. I have also indicated that the possible complications which I have discussed are those which I consider to be the most common ones, and that other, less common complications may occur, to which I have not specifically referred.

Physician/Designee Signature _____ Date _____ Time _____
 Interpreter services used in the patient's preferred language, interpreter ID or name: _____ Interpreter services declined

PART II: PATIENT CONSENT FOR SURGERY OR PROCEDURE

- A) The nature and purpose of the proposed operation/procedure, potential benefits and risks, including potential problems that might occur during recuperation; the alternative methods of treatment and their potential benefits and risks; and the possible results of non-treatment have been explained to me.
- B) The operation is to include whatever procedures are required in the performance of said operation. If any conditions arise during the operation or are revealed at the time of the operation that were not anticipated or recognized before and which call for procedures in addition to those originally contemplated, I authorize the performance of such procedures.
- C) I am aware that the practice of medicine is not an exact science and additional operations or procedures may be found necessary during the course of the proposed procedure. I acknowledge that no guarantees have been made or implied to me regarding the expected results of the operation or procedure.
- D) I understand that moderate sedation may be utilized for this procedure and the benefits, significant risks, the nature and purpose have been explained to me, as well as the possible results of not using moderate sedation.
- E) I understand that Robert Wood Johnson University Hospital ("RWJUH") is affiliated with Rutgers-Robert Wood Johnson Medical School (RRWJMS) and the State's University of Health Services.
- F) I have also been advised, and I understand that some attending physicians, medical fellows, residents, and students who may provide my care and treatment at RWJUH are employed by the State of New Jersey-RRWJMS. These physicians also wear name tags that clearly identify their association with RRWJMS.
- G) I understand what has been discussed with me as well as the contents of this consent form and I have been given the opportunity to ask questions and have received satisfactory answers.

I, the undersigned, hereby request and authorize Dr.(s) _____ (and whomever he/she may designate as his assistant(s)) to perform the operation or procedure proposed and described above in Part 1 A) and B).

I acknowledge that I have read the physician's certification above and/or that it has been read to me and that its contents including the risks, benefits and alternatives, have been explained to me. I agree that the information referred has been discussed with me and that I have been given the opportunity to ask further questions about any areas which were not clear to me and I am satisfied with the explanation and all of my questions have been answered to my satisfaction.

Signature of Patient or Signature of Person Authorized to Give Consent _____ Date _____ Time _____

Relationship of Person Authorized to Give Consent _____



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PART III: INFORMED CONSENT BY TELEPHONE

Date: _____ Time: _____

Name of Person Authorized to Give Consent

Relationship of Person Authorized to Give Consent

Telephone Number of Person Giving Consent

Print Name of Physician who Obtained Consent

Signature of Physician who Obtained Consent

Print Name of Witness to Telephone Consent

Signature of Witness to Telephone Consent

PART IV: CONSENT FOR PHOTOGRAPHY

I consent to the taking and publication of any photographs in the course of the performance of the procedure listed in Part I on this form for the purpose of advancing medical education.

Signature of Patient or Person Authorized to Give Consent

Relationship of Person Authorized to Give Consent

PART V: CONSENT FOR OBSERVERS

For the purpose of advancing medical education or if presence is requested by attending physician (i.e. Medical Device Representative), I consent to the admittance of observers to the operating room during the performance of the procedures listed in Part I of this form.

Signature of Patient or Person Authorized to Give Consent

Relationship of Person Authorized to Give Consent

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