

## INFORMED CONSENT FOR OPERATIONS AND/OR MEDICAL PROCEDURE(S) OR TREATMENTS

PROCEDURES:

PHYSICIAN:

- 1) I hereby authorize the above-named physician and/or associates or assistants of his/her choice to perform the operation(s) and/or procedures indicated above or any other therapeutic procedure upon me they may deem necessary or advisable. This procedure has been explained in terms understandable to me. The explanation has included:
  - a) The nature and extent of the procedure to be performed;
  - b) The risks involved, including those, even though unlikely to occur, involve serious consequences;
  - c) Alternative procedures and methods of treatment;
  - d) The dangers and possible consequences of such alternatives (including not having the procedure or treatment);
  - e) The estimated period of incapacity and the estimated period of convalescence (assuming there are no complications);
  - f) The expected consequences of the procedure upon my future health.
- 2) I have had the opportunity to ask questions regarding this procedure. Those questions have been answered to my satisfaction.
- 3) I understand that no assurance can be given that the procedure will be successful, and no guarantee or warranty of success or cure has been given to me.
- 4) I further authorize and request my physician and his/her associates, assistants and appropriate hospital personnel to perform such additional procedures, which in their judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment.
- 5) I hereby authorize the above-named physician to use his/her discretion in the retention, preservation, or disposal of any tissue or parts, including foreign objects consistent with the hospital's policies and procedures.
- 6) I understand that during the course of the operation, photographs, moving pictures or other visual recordings may be taken of the procedure or specimen and maintained as part of the hospital or physician's confidential records.
- 7) **Blood transfusion:** I am aware that, as a result of my condition, the transfusion of blood products may become necessary. The reasonable benefits, alternatives and potential risks of this treatment have been explained to me. Alternatives to volunteer blood donor products include: use of my own blood (autologous), directed (from friends or relatives), both require advanced preparation; intraoperative blood salvage (my blood collected during surgery), erythropoietin agents (injection given days prior to surgery to increase blood count) and use of blood volume expanders only. The precautions taken by my physician and the testing and screening of donors and their blood products generally prevent complications of transfusion. Donated blood is tested for various diseases such as syphilis, AIDS and Hepatitis. Blood that test positive is rejected. I understand that I may still be subjected to adverse effects as a result of receiving blood products, such as rash, hives, chills, fever, nausea, allergic reactions, transmission of diseases such as Hepatitis, AIDS, and other diseases, known and unknown, fluid overload, fluid leak into lungs, anaphylactic shock and death. The benefits of transfusion of a blood product (such as red blood cells, platelets, plasma, cryoprecipitate and granulocytes) are to preserve life and promote recovery after surgery. The risks of transfusion are extremely low.

Patient Name (Print) \_\_\_\_\_ Patient/Relative/Guardians Signature \_\_\_\_\_

Relationship (If Other Than Patient) \_\_\_\_\_ Date/Time \_\_\_\_\_

Witness (Print) \_\_\_\_\_ Witness Signature \_\_\_\_\_

2nd Witness (Print) for telephone/fax \_\_\_\_\_ 2nd Witness Signature for telephone/fax \_\_\_\_\_

### PHYSICIAN'S STATEMENT OF INFORMED CONSENTS

I hereby certify that I have explained the nature, purpose, benefits, risks, of and alternatives to the above-named procedure(s) /operation(s). (When applicable) I have counseled this patient regarding the possible use of blood and/or blood products, its benefits, attendant risks and alternative options including autologous blood, directed donor and intraoperative blood salvage.

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PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE/TIME