Use Ball Point Pen Only **Consent for Operation or Procedure**

PATIENT: _____

I authorize Dr. _____, his/her associates and such assistants as may be selected or designated by him/her to perform upon myself/the patient the following operation/procedure:

_____

_____

In simple language, _____

_____

_____

The nature and purpose of the operation/procedure to be performed, the benefits of the operation/procedure, the risks involved, treatment risks and benefits of alternatives, and the possibility of complications during and after the procedure have been explained to me. I understand that during the course of the operation, unforeseen conditions may become apparent which require an extension of the original procedure, or a different procedure from that described above. I also understand that other physicians or practitioners may assist my doctor or perform tasks during the operation/procedure, in accordance with privileges granted to them and their scope of practice. The risks of non-treatment have also been discussed and any potential problems that may occur during recuperation have been discussed and explained. I have had the opportunity to ask questions and satisfy any need for information that I feel is necessary.

I, therefore, authorize my physician, his associates or assistants to perform such surgical procedures as they, in the exercise of their professional judgment, deem necessary and desirable. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees or assurances have been made to me about the results of the operation/procedure.

If applicable:

- I consent that students training to be physicians, nurses, and other allied health personnel may assist in providing my care. I understand that healthcare industry representatives or visitors may be present in the operating room with the approval of the physician and hospital.
- I consent to the administration of anesthesia as may be considered necessary or advisable by the judgment of the attending representative of the Department of Anesthesiology and the physician.
- I authorize the disposal by hospital authorities of any tissue which may be removed during the course of this operation/procedure.
- I also give consent to Randolph Health Systems to make any photographic or other illustrations of the above named patient deemed advisable for diagnostic, scientific or educational purposes. I further authorize the use of such unidentifiable illustrations for teaching purposes or for scientific papers or lectures.

Witness: _____ _____

(Signature of Patient or Person Authorized to Consent for Patient)

Date: _____ Time: _____ Date: _____ Time: _____

_____

(Authority to Consent for Patient)

_____

(Reason Patient Cannot Sign)

Interpreter Signature or Language Vendor Identifier: _____ Date: _____ Time: _____

I have discussed with the patient or patient's legal representative the nature and purpose of the operation(s)/procedure(s) listed above, possible treatment alternatives, the benefits and risk involved, and possible complications, and the above patient/patient's legal representative indicated he/she understands what is intended and agreed to proceed with the operation(s)/procedure(s).

_____ _____ _____

(Signature of Physician Who Explained Operation/Procedure) Date Time

(This Form Must Be Completed Prior to Surgery)

Randolph Health