Informed Consent for Surgery or Special Procedures

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1. **Authorization.** I, _____ (Name of Patient) authorize _____ (Name of Practitioner) and any appropriate designees selected by my Practitioner, to perform the following surgery or special procedure(s) (the "Procedure"):

   Name and Description of the Procedure (must be completed by Practitioner): _____

   _____

   _____

   _____ ☐ Right ☐ Left ☐ N/A

2. **Surgery or Special Procedure.** The following information has been discussed with me about the Procedure listed above: (a) the nature and intended purpose; (b) the potential risks, benefits and side effects, including any possible duration of incapacity and potential problems that may occur during recovery from the Procedure; (c) the reasonable alternatives, including the potential risks, benefits and side effects related to those alternatives; (d) the risks and consequences of not receiving the Procedure; and (e) the possible or likely results of the Procedure, including my likelihood of achieving treatment goals.

3. **Additional Procedures.** I understand that during the course of the Procedure, unforeseen conditions may arise that require additional or different procedure(s) other than the Procedure listed in Paragraph 1. I authorize and request that my Practitioner and any appropriate designees perform such other procedures as necessary in the exercise of their professional judgment. This authority extends to treating all conditions that are unknown to me at the time the Procedure is undertaken.

4. **Blood Transfusions.** I understand that I may need a transfusion(s) of blood and/or blood products in connection with the Procedure. I have been given and have read the Patient Information Sheet on Blood Transfusions, and my Practitioner has discussed with me the following information about blood transfusions:

   (a) The reason(s) I may need a blood transfusion; the nature and intended purpose; the potential risks, benefits and side effects, including any potential problems that may occur during recovery from the transfusion(s); the reasonable alternatives, including the potential risks, benefits and side effects related to those alternatives; the possible options including autologous, homologous and directed donation; any possible duration of incapacity; the risks and consequences of not receiving a transfusion(s); and the possible or likely results of the transfusion(s), including my likelihood of achieving treatment goals.

   (b) That a blood transfusion is not always successful and that no guarantee or assurance has been made to me or anyone concerning the benefits or results of a transfusion, and that I may be subject to ill effects as a result of receiving blood and/or blood products.

   (c) That this consent applies to all transfusions I may receive related to the Procedure.

   For blood transfusions, I have decided:

   (a) I CONSENT to receive blood and / or blood products. ☐ Yes ☐ No

   (b) If I DO NOT CONSENT to receive blood and blood products, I understand that my refusal to have a blood transfusion may cause serious illness and possible death. I further understand that I will be offered registration in the Blood Alternative Program. _____ (Patient must initial if refusing blood and blood products.)

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5. **Anesthesia.** I have been given and have read the Patient Information Sheet on Anesthesia and I consent to the administration and management of such anesthesia as the anesthesiologist assigned to my Procedure deems appropriate. I have also been given and have read the Patient Information Sheet on Moderate Sedation/Analgesia ("Conscious Sedation") and I understand that moderate sedation may be administered by a doctor other than an anesthesiologist, or by a nurse under the direction of a doctor, and I consent to the administration and management of such moderate sedation as the doctor deems appropriate. I have been informed of the risks most commonly associated with the administration of anesthesia and moderate sedation. I am aware that complications from all forms of anesthesia and moderate sedation are rare, but may occur.

6. **Radiation.** I have been given and have read the Patient Information Sheet on the use of x-rays during my procedure. I consent to the administration of x-rays as my Practitioner deems appropriate. I have been informed of the risks most commonly associated with the exposure to radiation.

7. **Specimens.** I consent to the examination and disposal of any specimens, tissues, and/or parts removed in the performance of the Procedure. I understand that once they are disposed, they cannot be retrieved. I understand and agree that the Hospital may use such specimens, tissues, and/or parts for medical education. I further understand that the law allows my specimens and/or tissues to be used for research without my authorization if my identity is not linked to the specimens and/or tissues. If my identity will be linked to my specimens and/or tissues, they will not be used for research unless I provide authorization.

8. **Vendors.** I understand that vendors and/or sales representatives associated with equipment and supplies used for the Procedure may observe or be present in the operating room.

9. **Acknowledgement.** I understand the practice of medicine and surgery is not an exact science, and that the Procedure may not have the benefit or results intended. I acknowledge that no guarantees or assurances have been made to me concerning the benefits or results of the Procedure.

Statement of Patient or Patient's Representative. I certify the following to be true:

A. I have read and understand the information in this informed consent form.
B. The information referred to in this informed consent form has been explained to me by my Practitioner.
C. I have had the opportunity to ask and have had answered to my satisfaction all of my questions about the Procedure, including any questions about blood transfusions, anesthesia, and radiation.
D. I believe that I know enough about the Procedure to make an informed decision and that by signing below, I give my consent for the Procedure.

Patient's Signature _____ Date _____ Time _____

Only if Patient is unable to consent, complete the following:

Name of Patient's Authorized Representative _____ Relationship to Patient _____

Signature of Patient's Authorized Representative _____ Date _____ Time _____

Reason Patient Cannot Consent _____

Name of Witness _____ Signature of Witness _____

Statement of Practitioner Obtaining Consent: I certify that I have had the informed consent discussion with the patient or patient's representative and have answered any questions related to the Procedure.

Practitioner's Signature _____ Date _____ Time _____