

# SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURE CONSENT FORM

1. **OPERATIONS AND PROCEDURES.** I agree to have Dr. \_\_\_\_\_ (“Surgeon”), and any associates or assistants selected by the Surgeon, do the following operation(s) or procedure(s) on \_\_\_\_\_ (“Patient”):

Hereinafter referred to as “Procedure.”

2. **RISKS.** All Procedures have risks, including bleeding, infection, and even death.

I have been informed of such risks, as well as the nature of the Procedure, the likelihood of achieving goals, the expected benefits or effects of such Procedure, including side effects and potential problems that might occur during recuperation, and the reasonable alternative methods of treatment and their risks and benefits. I have also been informed of the consequences of declining the Procedure and the reasonable alternatives.

3. **ADDITIONAL PROCEDURES.** I agree to have additional procedures if, during the Procedure, my Surgeon decides they are needed for reasons not known before the Procedure. I also authorize my Surgeon to provide or arrange for the provision of additional services, as necessary or advisable, including but not limited to, pathology and radiology services.

4. **RESIDENT PHYSICIANS AND STUDENTS.** Resident physicians and students may work with the Surgeon. Resident physicians may do part of the Procedure. The Surgeon will decide at the time of the Procedure which residents will take part. What they are allowed to do will depend upon their skill and the Patient’s condition. Residents will be under the supervision of the Surgeon.

There are times when an attending surgeon will oversee the care provided by teams in two operating rooms simultaneously, defined as concurrent staffing. The Surgeon or an attending designee will be present for all the critical parts of the Procedure. The Surgeon may be out of the operating room for some or all of the surgical tasks done by residents if the Surgeon decides it is safe to do so.

5. **ASSISTANTS.** Trained licensed people who are not physicians may do part of the Procedure or administer the anesthesia. They will be only doing things allowed by the hospital and by law.
6. **VISITORS.** My Surgeon may have health care industry representatives or other visitors present in the operating room for technical support related to my treatment, and unless noted below, I authorize those individuals to be present.

- I DO NOT authorize health care industry representatives or other visitors to be present in the operating room.

7. **VENDOR RELATIONSHIP.** My Surgeon does not have any financial or research interest in the Procedure (including but not limited to a consulting or services agreement, or receipt of research funding) with a vendor of any products or devices used in the Procedure, other than his/her professional fees, unless noted below:

\_\_\_\_\_ (initial if applicable) - My Surgeon has informed me that he/she has a financial relationship with a vendor of products or devices used in the Procedure.

8. **SPECIMENS.** The hospital may keep, use, or dispose of anything removed during the Procedure ("Specimens"). Specimens may be used for research. I do not own the Specimens, or data derived from Specimens, and have no right to any research or research product using or derived from the Specimens. Specimen includes, but is not limited to, any tissues, organs, bones, bodily fluids, or medical devices.
9. **RIGHTS, GUARANTEES, AND QUESTIONS.** I have the right to consent to or to refuse any proposed operation or procedure, including the Procedure, at any time prior to its performance.

I am aware that the practice of medicine and surgery is not an exact science, and no guarantee has been made as to the results of the Procedure or any cure. I also understand that the explanations that I have received may not be exhaustive or all-inclusive and that other more remote risks may be involved. However, the information that I have received is sufficient for me to consent to the Procedure. I have had a full opportunity to ask questions concerning my condition, the Procedure, the risks, and the alternatives. All of the questions that I have asked have been answered to my satisfaction.

10. **IMPLANTABLE DEVICE.** I understand that if an implantable device is used, information regarding the device and my Social Security number may be reported to the device manufacturer, if requested, and as required by federal law.

**MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGMENT THAT:**

1. I have read and understood the information contained here;
2. I have been informed about the Procedure and the potential risks, benefits, alternatives and the risk of those alternatives;
3. I authorize and consent to the performance of the Procedure as described; and
4. I authorize and direct that any Specimen removed during the Procedure is to be handled as indicated above.

**Patient Signature:** \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Parent, Guardian, or Conservator Signature:** \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Print Name: \_\_\_\_\_

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**I have discussed the above information with the Patient.**

**Surgeon Signature:** \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Translator Attestation**

**I have accurately and completely read this consent form to the Patient or the Patient's legal representative in the Patient's or Legal Representative's primary language of \_\_\_\_\_. He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.**

**Translator Signature:** \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Print Name: \_\_\_\_\_

Translator ID #: \_\_\_\_\_