



## CONSENT TO OPERATION, TREATMENT OR OTHER PROCEDURE

	authorize Dr		(patient) the following elective,				
medicall	ly necessary, or emergent operatior	, treatment, or other procedure:					
benefits if any, ar my cond made co the desir	In doctor has explained the nature, advisability and purpose of the operation, treatment or other procedure, together with the anticipated enefits; the potential risks of side effects and the possibility of complications; and alternatives to the operation, treatment or other procedure any, and the risks of such alternatives. My doctor has explained what to expect if I have the operation or procedure and what could happe by condition remains untreated. I understand the information that has been given to me and I understand that no guarantee or promises car hade concerning the results of my operation, treatment or procedure, however, my physician has explained to me the likelihood of achievin he desired results.						
Benefits	:	Alternatives:					
1.	I understand that some important s assistant surgeons, providers or re set. These tasks are expected to be None	esidents under the supervision of my doctor, ac	or procedure may be performed by other doctors, cording to hospital policy and based on their skill				
2.	I authorize the physician to mark c the procedure, as necessary.	orrect surgical site for my operation, treatment	, or procedure with a temporary skin marker prior				
3.		inistration of anesthesia by the anesthesiology	staff or my physician.				
4.	I understand that during the course extension of the original operation,		e unforeseen conditions may be found that make a norize and consent to such extension or other				
5.	I authorize and consent to the disp	osal, use, retention or donation by the hospital, removed in the course of the operation, treatm	at its discretion, of all tissues, materials and				
6.		to be present during my surgery or procedure	•				
7. 8.	I understand that I may need a tran physician has described the risks,	sfusion of blood or blood products during this of benefits and alternatives of a transfusion.					
	blood flow, replacement of red bloo	od cells or platelets, and sustaining of life.	maintenance of blood pressure, improvement of s and risks of receiving blood and blood products				
	threatening condition such as lung hepatitis or HIV (AIDS) because the	ey cannot be made completely safe with current	ducts may transmit infectious diseases, including t scientific knowledge.				
			supplies of blood for transfusion which may not or general wellbeing. Initial below you authorization				
	I do I do not author	ze and consent to the transfusion of such blood	l products. 🗆 N/A				
9.	understand that I should not sign that if I want a further or more deta risks and consequences, it will be	nis form if all items have not been explained or a					
l met wit as well a	h as the associated risks, benefits, and	(patient / authorized representative)	and fully discussed the above-described procedur				

Signature of Person Performing Operat	ion, Treatment, or Procedure	Date	/ Time	
Signature of Patient or Legally Authoriz	ed Representative	Date	/ Time	
Relationship of Representative			Reason patient is unable to sign	
Signature of Witness			Date	/ Time
Patient Name:	HSC:	Account #:	Patient Sticker	R #:
	dmitted:		Att. MD:	
FORM # 22-0002				