Wayne Memorial Hospital

INFORMED CONSENT TO SURGICAL PROCEDURE

It is very important to your doctor that you understand and consent to the treatment your doctor is rendering and any surgery your doctor may perform. You should be involved in any and all decisions concerning the surgical procedure. Sign this form only after you understand the procedure, the risks, the alternatives, the risks associated with the alternatives, and all of your questions have been answered. **Please initial and date directly below this paragraph indicating your understanding of this paragraph.**

_____ _____

Patient's Initials or Authorized Representative **Date**

I, _____, hereby authorize Dr. _____and any associates or assistants the doctor deems appropriate, to perform (**circle one**: ☐ LEFT, ☐ RIGHT, ☐ BOTH, ☐ UNILATERAL)_____

_____.

I consent to have _____ (name and title) perform the following tasks (list): _____.

The risks and benefits associated with the procedure have been explained to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure(s). I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being and safety.

The risks and possible undesirable consequences associated with the procedure have been explained to me including, but not limited to, blood loss, transfusion reactions, infection, heart complications, blood clots, loss of or loss of use of body part or other neurological injury or death. Other risks may include:_____

_____

_____

I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, Hepatitis, or reactions such as the symptoms of fever, chills, hives or in more severe reactions, the destruction of the transfused red cells (Hemolytic Transfusion Reaction), antibody stimulation, bacterial infections or, in rare situations, death.

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In permitting my doctor to perform the procedure(s), I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his assistants, or his designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.

The reasonable alternative(s) to the procedure(s) have been explained to me. These alternatives include but are not limited to: _____

_____

I hereby authorize my doctor to utilize or dispose of removed tissues, parts or organs resulting from the procedure(s) authorized above. I consent to any photographing or videotaping of the procedure(s) that may be performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them. I also consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information. As required by the Safe Medical Device Act, I consent to the release of my name, address, and social security number to the manufacturer of any medical device I receive.

By signing below, I have had an opportunity to ask the doctor all questions concerning risks, alternatives, and risks of those alternatives.

_____	_____	_____	_____
Date	**Time**	**Signature of Patient or Authorized Representative**	**Relationship of Authorized Representative**

☐ The Patient/Authorized Representative has read this form or had it read to him/her.

☐ The Patient/Authorized Representative states that he/she understands this information

☐ The Patient/Authorized Representative has no further questions.

_____	_____	_____
Date	**Time**	**Signature of Witness**

CERTIFICATION OF PHYSICIAN:

I hereby certify that the facts, risks, the risks associated with the alternatives of the procedure(s) described in this form have been discussed with the individual granting consent.

_____	_____	_____
Date	Time	Signature of Physician

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