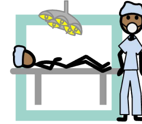
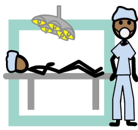
PATIENT INFORMED CONSENT FOR SURGERY & SEDATION

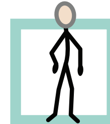
Patient Identifcation



My doctor (Dr. ____________________) will do my surgery.



The surgery is called: ________________________________.



Procedure Site: The surgery is for this part of my body: ______________.

PATIENT INFORMED CONSENT FOR SURGERY & SEDATION

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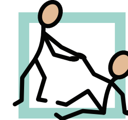
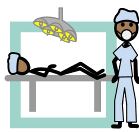
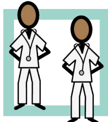


My doctor told me that other health care workers may help



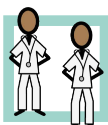
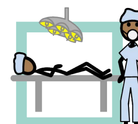
with my surgery.

The health care workers might be:

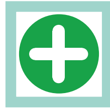
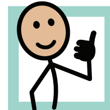


1. doctors who work with my doctor.

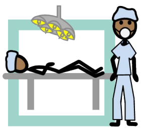
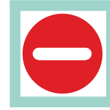
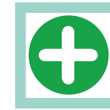
2. nurses

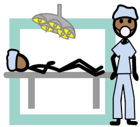
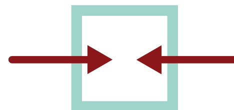
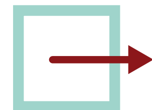
3. doctors who are learning to do the surgery.

Risks are bad things and benefits are good things that can happen

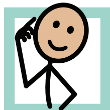
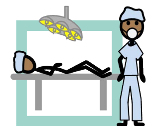
  

from my surgery. My doctor told me the risks and benefits from

my surgery. The risks could happen during my surgery or after.

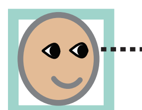
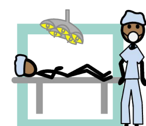
Risks

I understand that these bad things could happen from my surgery:

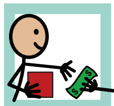
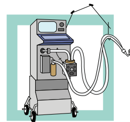
____

____

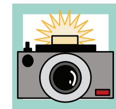
 

○ My doctor told me that an **observer may watch my surgery**.

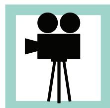
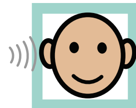
These are sometimes students and sometimes people who

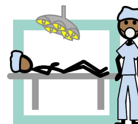
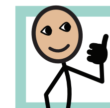



support or sell surgical equipment.



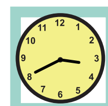
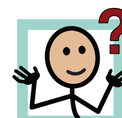
○ My doctor told me that health care workers might take photographs,

videos, or sound recordings of my surgery. It is ok for the pictures or recordings to be used for other doctors to learn the procedure or if my medical insurance needs them to pay my bill.

○ My doctor asked me if I wanted more information.

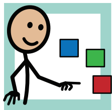



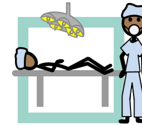
○ I understood my doctor and had time to ask questions.

PATIENT INFORMED CONSENT FOR SURGERY & SEDATION

Patient Identiÿcation

○ My doctor told me about the surgery and told me about my other





options, including no treatment. I agree to have the surgery.

/ / : ☐ am ☐ pm

(Patient's Signature*) (Print First/Last Name) (Date) (Time)

I EXPLAINED THE ABOVE PROCEDURE(S) OR TREATMENT TO THE PATIENT:

/ / : ☐ am ☐ pm

(Qualiÿed Personnel's Signature) (Credentials) (Print First /Last Name) (Date) (Time)

☐ Check to indicate patient has signed using a name, word, mark or symbol other than legal name.

☐ * Patient is unable to consent because: ____________________

If the Patient is unable to consent, complete Section A, B or C below, as applicable.

A. The patient has a Legally Authorized Health Care Representative:

As the Patient's (check **one**): ☐ Parent (if patient is a minor); ☐ Legal Guardian; ☐ Health Care Representative; ☐ Relative Caregiver (requires a°da vit), I give my permission and consent for the patient to the treatment(s) or procedure(s) speciÿed above:

/ / : ☐ am ☐ pm

(Authorized Consenter's Signature) (Credentials) (Print First /Last Name) (Date) (Time)

I EXPLAINED THE ABOVE TREATMENT(S) OR PROCEDURE(S) TO THE PATIENT LEGALLY: AUTHORIZED HEALTH CARE REPRESENTATIVE.

/ / : ☐ am ☐ pm

(Qualiÿed Provider's Signature) (Credentials) (Print First /Last Name) (Date) (Time)

PATIENT INFORMED CONSENT FOR RENDERING OF MEDICAL SERVICES/ SURGICAL SERVICES/SEDATION

Continued from Page 4 (if applicable)

Patient Identiÿcation

B. The patient does NOT have a Legally Authorized Health Care Representative:

As the patient's (ÿll in relationship to patient) ______________________ , I agree that the treatment(s) or procedure(s) have been fully explained to my satisfaction, is in the best interest of _______________ , and I consent for the patient:

_______________________________________ / / : ☐am ☐pm

(Consenter's Signature) (Print First /Last Name) (Date) (Time)

I ATTEST :

- **THE PATIENT'S INCAPACITY HAS BEEN DOCUMENTED IN THE PATIENT'S MEDICAL RECORD**
- **THE MEDICAL NEED FOR THE PROCEDURE OR TREATMENT HAS BEEN DOCUMENTED IN THE PATIENT'S MEDICAL RECORD, AND**
- **I HAVE EXPLAINED THE ABOVE PROCEDURE(S) OR TREATMENT TO THE CONSENTER NAMED ABOVE:**

_______________________________________ / / : ☐am ☐pm

(Qualiÿed Provider's Signature) (Credentials) (Print First /Last Name) (Date) (Time)

C. The patient does NOT have a Legally Authorized Health Care Representative OR any family member/friend that can be reasonably located or is willing to represent the patient's insterests:

I ATTEST :

- **THE PATIENT'S INCAPACITY HAS BEEN DOCUMENTED IN THE PATIENT'S MEDICAL RECORD**
- **THE MEDICAL NEED FOR THE PROCEDURE OR TREATMENT HAS BEEN DOCUMENTED IN THE PATIENT'S MEDICAL RECORD, AND**
- **THE HEALTH CARE SURROGATE COMMITTEE HAS CONSENTED TO THE PROCEDURE OR TREATMENT ON THE PATIENT'S BEHALF AND SUCH DECISION HAS BEEN DOCUMENTED.**

_______________________________________ / / : ☐am ☐pm

(Qualiÿed Provider's Signature) (Credentials) (Print First /Last Name) (Date) (Time)

FOR TELEPHONE CONSENTS:

_______________________________________ / / : ☐am ☐pm

(Witness' Signature for telephone consent only) (Print First /Last Name) (Date) (Time)

☐ **Mark this box if interpreter was involved with any of the signatures on this form.**