



5900T

Name of Patient: \_\_\_\_\_

Physician provider of information about procedure: \_\_\_\_\_

(A) (1) I acknowledge and understand that the following procedure(s) (including procedures and/or additional services, such as anesthesia, radiology, pathology and the like) including which has (have) been described to me is (are) to be performed on the patient,

Procedure: \_\_\_\_\_

and that as a result of the performance of the procedure(s) there is a material risk that the patient may suffer infection, allergic reaction, severe loss of blood, loss or loss of function of any limb or organ, paralysis, paraplegia or quadriplegia, disfiguring scar, brain damage, cardiac arrest, or death. In addition to the above, anesthetic procedures may also result in dental or nerve injury, headache or backache.

(2) I acknowledge and understand that during the course of the procedure(s) described in subparagraph (A) (1) above, conditions may develop which may reasonably necessitate an extension of the original procedure(s) or the performance of procedure(s) which are unforeseen or not known to be needed at the time this consent is obtained. I therefore consent to and authorize the persons described in the last paragraph of this consent to make the decisions concerning the performance of and to perform such procedure(s) as they may deem reasonably necessary or desirable in the exercise of their professional judgement, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment for all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time consent is obtained.

(B) The anesthesia considered suitable for this type of surgery/procedure has been presented to me in general terms through methods such as direct communications, videotapes, audiotapes, pamphlets or booklets. The Anesthetic Plan, including the method of administration, will be discussed with me by a member of the anesthesia group before the administration of any anesthetic medication. My anesthetic will be administered by an anesthesiologist, or an anesthetist under the direct supervision and control of an anesthesiologist.

(C) I acknowledge and understand and duly evidence in writing by executing this form that I have been informed in general terms of the following,

- (1) A diagnosis of the condition requiring the procedure(s)
- (2) The nature and purpose of the procedure(s)
- (3) The material risks of the procedure(s) (see paragraph (A) above)
- (4) The likelihood of success of the procedure(s)
- (5) The practical alternatives to such procedure(s), if any, and
- (6) The prognosis if the procedure(s) is (are) rejected and that all were provided through the use of video tapes, audio tapes, pamphlets, booklets, or other means of communication or through conversations with the responsible physician, or other medical personnel under the supervision and control of the responsible physician, other medical personnel involved in the course of treatment, nurses, physician's assistants, trained counselors, or patient educators.

(D) I acknowledge that there are practical alternatives to the procedure(s) described in paragraph (A) which alternatives reasonably prudent physicians generally recognize and accept.

(E) I acknowledge and understand that this request for and consent to surgical or diagnostic services and anesthesia procedures shall be valid for the responsible physician, all medical personnel under the direct supervision and control of the responsible physician, and for all other medical personnel otherwise involved in the course of treatment.

I have been given ample opportunity to ask questions and any questions I have asked have been answered or explained in a satisfactory manner.

By signing below, I acknowledge that I have read or had it read or explained to me and I understand this form and I voluntarily consent to allow Dr. \_\_\_\_\_ or any physician(s) designated or selected by him or her and all medical personnel under the direct supervision and control of such physician and all other personnel which may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

Signature of Patient or Authorized Person \_\_\_\_\_ Witness \_\_\_\_\_

Relationship of Authorized Person \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

**WAIVER OF RIGHT TO BE INFORMED**

I fully and completely **waive the right to be informed** of the information specified in paragraph (B) above **and request that such information not be disclosed to me.**

Signature of Patient or Authorized Person \_\_\_\_\_ Witness \_\_\_\_\_

Relationship of Authorized Person \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_



**CONSENT TO SURGICAL OR DIAGNOSTIC AND ANESTHESIA PROCEDURE(S)**

Patient ID Area

**CONSENT FOR TRANSFUSION OF BLOOD  
OR BLOOD PRODUCTS**

1. I consent to have blood and/or blood products transfusion(s) as may be deemed advisable by Dr. \_\_\_\_\_ or his/her designee and the risks, of refusal, benefits, and alternatives to blood or blood product transfusions have been explained to me.
2. I understand that no guarantee has been given by anyone as to the results that may be obtained.
3. Potential benefits of receiving blood or blood products include:
  - Restoring blood volume
  - Replacing clotting factors; and
  - Improving oxygen delivery to the body.
4. Potential risks of not receiving blood or blood products include:
  - Death
  - Heart attack
  - Stroke
  - Bleeding.
5. I understand that reactions are very unusual. The potential risks of blood or blood products include, but are not limited to:
  - Temporary transfusion reactions such as headache, fever, chills, rash, and difficulty breathing;
  - Hepatitis;
  - Severe transfusion reactions potentially resulting in death;
  - HIV (Human Immunodeficiency virus) (AIDS); and
  - Other infectious agents.
6. Potential alternatives to receiving community supplied blood or blood products include:
  - Donating my blood several weeks in advance;
  - Friends/relatives with compatible blood donating blood for me, if donated weeks in advance;
  - Cell saving technology (capturing and returning my own blood); and
  - Intravenous (IV) fluids to increase volume.

I, the undersigned, have had this blood / blood component and transfusion consent explained to me and fully understand the contents of this authorization.

Signature of Patient or Authorized Person	Witness
Relationship of Authorized Person	Date <span style="float: right;">Time</span>

**REFUSAL OF BLOOD OR BLOOD PRODUCTS**

I refuse the use of any blood and/or blood products. I understand the risks of not receiving blood and/or blood products.

Signature of Patient or Authorized Person	Witness
Relationship of Authorized Person	Date <span style="float: right;">Time</span>

Patient ID Area