

Planned Procedure/Treatment

Diagnosis/Reason for Procedure/Treatment

Provider _____ has discussed with me the nature of my medical condition and the nature and purpose of the procedure or treatment named above. I understand the expected results of this procedure or treatment in my specific case as compared with the results to be expected with other forms of treatment or the consequences of no treatment at all, and potential complications related to recovery. I understand that any body fluids or tissues removed during the procedure or treatment may be analyzed and/or preserved for scientific or teaching purposes and/or disposed of in accordance with acceptable medical practice.

We discussed that there may be discomfort and risks associated with this procedure or treatment including but not limited to bleeding, infection, blood clots, drug reactions, brain damage and death. We discussed other risks more specifically associated with the intended procedure or treatment and that unexpected complications could occur.

We also discussed the possibility that, during the procedure or treatment named above, it may be necessary in an emergency or in the provider's judgment to change the procedure or to perform other treatments not specifically discussed today.

BLOOD - I consent to the administration of blood or blood products if necessary in the judgment of the provider. This consent is valid for the duration of the admission. The risks, alternative and possible side effects associated with blood transfusions have been explained to me. I also understand that I may refuse to receive blood and blood products and understand the risks of this decision and release any providers participating in my care from any responsibility for unfavorable or untoward results caused by my refusal to permit a transfusion. If I choose to refuse blood products, I will complete the refusal of blood products informed consent.

SEDATION/ANALGESIA- The provider has explained that for my comfort local anesthetics, sedatives, and painkillers may be given to produce a general state of sedation during the procedure. I understand that potential complications of these medications can include lowering of blood pressure, reduction in breathing and blood oxygen, airway obstruction, and heart rhythm disturbances.

RADIATION/RISK (if applicable) - My sensitivity to radiation due to previous procedures, disease, or genetic conditions will be considered. I understand the utilization of x-rays for imaging during the procedure and for documenting the results. I have been provided with information on the risks associated with the use of radiation including the possibility of a localized skin reaction and/or a small increase in the incidence of cancer in my lifetime.

I understand that healthcare industry representatives may be present for my procedure if requested by my physician or the hospital as a resource for equipment or products. Students of clinical health care programs, and/or medical professional staff or other ancillary patient care professionals affiliated with the hospital or surgeon for educational purposes may also be present. _____ By initialing here I am indicating that I do **NOT** consent to having any of the above listed health care professionals present during my procedure, and have specifically discussed these wishes with my physician.

Finally, I understand that medicine is not an exact science and that no guarantees can be made about the outcome of this procedure or treatment. In signing this form, I certify that the discussion took place to my satisfaction with all my questions answered fully and that I authorize and request that the procedure or treatment be performed by the provider and his/her assistants as required. I understand that I can change my mind and withdraw my request at any time before the procedure or treatment.

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| Patient/Legally Responsible Person Signature | Relationship | Date | Time |
| Provider Signature | Printed Name | Date | Time |
| Witness Signature REQUIRED for Verbal and Telephone consent (Otherwise OPTIONAL) | | Date | Time |

