SAINT AGNES HOSPITAL

PATIENT IDENTIFICATION

INFORMED CONSENT TO OPERATION/PROCEDURE, MEDICAL TREATMENT AND ANESTHESIA

(1) I hereby authorize Dr._____
and associate or assistant _____involved
in my care to preform procedure(s) planned for treatment of my condition.

(2) The procedure (s) planned for treatment of my condition has (have) been explained to me by my physician as Follows:

PROCEDURE (S)

_____

_____

_____

_____

(3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate my above-named physician and his or her assistants, to perform such additional surgical or other procedures as are necessary.

(4) I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.
Risks specific to this procedure:

_____

_____

_____

(5) No promise or guarantee has been made to me as to result or cure.

(6) I consent to the administration of (general, spinal, regional, conscious sedation, local) anesthesia by my attending physician, by an anesthesiologist, a nurse anesthetist, or other qualified parties under the direction of a physician as may be deemed necessary. I understand that my anesthesia practitioner will discuss anesthesia risks and benefits to me prior to the procedure.

ALL SECTIONS THAT APPLY BELOW MUST BE INITIALED BY PATIENT

_____ (7) I consent to the observation of the operative procedure for the purpose of advancing medical education.

_____ (8) Any tissues or part surgically removed may be disposed of by the hospital or physician in accordance with custom/legal practice.

_____(9) I consent to the photographing or televising of the operation or procedure to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided that my identity is not revealed by the picture or by descriptive texts accompanying them.

_____ (10) I consent to vendor presence in the operating room when deemed necessary.

_____ (11) In the event of surgical participants' needle and blade injury, I authorize my blood drawn for HIV and Hepatitis screening.

_____ (12) I understand that tissue products may include donated human tissue (skin for example), products made from human tissues and other items which contain animal parts. One or more of the same or similar products may be implanted into my body during surgery if needed.

Any additional comments, complications, other planned procedures, and other surgeon's names may be inserted here:_____
_____
_____
_____
_____

_____
PATIENT INITIALS

SAINT AGNES HOSPITAL

PATIENT IDENTIFICATION

FULL DISCLOSURE

I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

A) Diagnosis or probable diagnosis
B) Nature of treatment or procedures recommended
C) Risks or complications involved in such treatment or procedures
D) Alternative forms of treatment, including non-treatment, available are described below:

_____

_____

E) Anticipated results of the treatment.

F) Possible circumstances under which information about me must, by law/regulation, be disclosed or reported such as diagnosis of specific communicable diseases.

I have the opportunity to ask questions about this procedure and they have been answered to my satisfaction.

_____	_____	_____	_____
Patient/other Legally Responsible Person Relationship if Applicable Signature	**Professional Witness**	**Date**	**Time**

I have fully explained to the patient or patient's authorized representative the nature of the procedure, the risks, possible complications and expected benefits or the effects of the procedure and any other alternatives to the treatment and their risks and benefits**.**

_____	_____	_____
Physician's Signature	**Date**	**Time**

_____
Physician Printed Name

==========

PRE-PROCEDURE TIME OUT BEDSIDE PROCEDURES

_____ Patient's name and date of birth match wristband and consent form.

_____ Intended procedure matches consent form.

_____ Intended side/site identified, and matches consent form if applicable.

_____	_____	_____
Signature of Individual Documenting Time Out	**Date**	**Time**

(Completed by person other than one performing procedure)