

UNITY HEALTH SYSTEM

**CONSENT FOR SURGICAL PROCEDURE
OR INVASIVE PROCEDURE**

I Hereby authorize Dr. _____ and his/her designee as assistants to perform upon
_____ (Name of patient) the following procedure:

(State nature of procedure to be performed)

The nature and purpose, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I recognize that the explanation I have received is not exhaustive and that other, more remote risks could arise. I recognize that a more detailed explanation can be given at my request. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from the procedure.

I acknowledge that certain conditions may be revealed to the physician involved at the time of the procedure which were not recognized before and which may call for procedures in addition to those originally contemplated; I authorize the performance of such procedures in accordance with the judgment of the operating surgeon or physician involved.

I consent to the administration of anesthesia or conscious sedation by a physician, and the use of such anesthetics as deemed advisable.

I consent to photographing, videotaping or medical illustrating of the procedure or tissues removed, for medical, scientific, or educational purposes, provided my identity is not revealed.

I consent to the presence of medical equipment company representatives in the operating room and to their provision of technical support to the operating physician involved in the procedure, in no event does this consent permit performance of a procedure by such representatives.

The merits and risks of the blood and blood products, the consequences of the refusal to use blood and blood products, and the available alternatives to the use of blood and blood products, including self-donation, and use of a designated donor have been fully explained to me. I consent to the use of blood or blood products if deemed necessary by the physicians involved in my care.

I consent to the disposal of any tissue or body parts removed in the course of the operation by hospital authorities or designee.

I acknowledge that I was given the opportunity to ask questions during the course of all explanations given to me as described above and that I have received satisfactory answers to my question.

I certify that I have read and fully understand the above consent after adequate explanations were made to me, after all blanks were filled in, and inapplicable paragraphs, if any, were crossed out. Specific exceptions to this consent are listed below:

Signature of Patient: _____ Date: _____

When patient is a minor, or lacks capacity to consent, signature of person authorized to consent for patient:

(Name) (Relationship)

I have agreed that I have provided all appropriate information to the above patient regarding the procedure identified above.

Physician/other practitioner _____ Date: _____
(Signature)