CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC
OR THERAPEUTIC PROCEDURES

Patient Name: ____

Proposed operation(s) or procedure(s): ____

____

I, the patient or the patient's legally authorized representative, hereby request and consent to the procedure described above and hereby authorize and direct ______________________________, M.D. / D.O. and his/her associates or assistants, if any, to perform the operation(s) or procedure(s) described above and to perform or order any other procedure or services, such as anesthesia, radiology, pathology and the like, as may be advisable for my well being.

BY SIGNING BELOW, I ACKNOWLEDGE AND AGREE THAT I HAVE READ (OR HAD EXPLAINED TO ME) THE FOLLOWING:

1. The nature, purpose, risks and possible benefits of, and alternative to the operation(s) or procedure(s) have been explained to me by my physician_________________________ and I have all of the information that I desire. Any questions I asked were answered to my satisfaction. No guarantee or assurance has been made as to the possible results. I understand that my consent is voluntary.

2. I also agree to filming or recording of the procedure for education or documentation purposes by the physician(s) performing the procedure.

3. I understand and agree that during the procedure/operation and in the recovery room or equivalent, full resuscitative efforts will be used if my heart or breathing should stop. I will discuss with my physician and the hospital providers if I do not want any such resuscitation or other treatment used during the procedure/operation or post-anesthesia period.

4. I hereby request and voluntarily consent to the operation(s) or procedure(s) and filming or recording described above.

Patient / Legal Representative: ____

Relationship to Patient: ____

Witness: ______________________________ Date: ______________ Time:____________

If patient unable to sign due to legal, mental, or physical incapacity, state reason: ____________________

I have explained the risks and benefits of and alternatives to the scheduled procedure to the patient and/or patient representative. The patient's and/or patient representative's questions were answered.

Physician Signature:____________________________________Date__________Time__________

#3 – New item added to the surgical consent beginning October 17, 2011

Added to Consent Form

Effective 10/17/11

I understand and agree that during the procedure/operation and in the recovery room or equivalent, full resuscitative efforts will be used if my heart or breathing should stop. I will discuss with my physician and the hospital providers if I do not want any such resuscitation or other treatment used during the procedure/operation or post-anesthesia

If the patient **does not want the DNR status suspended during the Perioperative period, the surgeon/physician who will complete the procedure must**

1. Discuss and come to an agreement with the patient/legal representative regarding the perioperative code status
2. Enter a specific order in the medical record specifying what resuscitative efforts are allowed (e.g. N**o chest compressions** but intubation and medications ok)