Consent for Operative and/or Diagnostic Procedures

1. I hereby authorize Dr. ________________________________ and/or Dr. ________________________________ at ____________________________ to perform upon me or the named patient the following operations and/or course of treatment (explain in plain English):

   ____
   including such photographing, videotaping, televising or other observation of the operation(s)/procedure(s) as may be purposeful for the advance of medical knowledge and/or education, with the understanding that my/the patient's identity will remain anonymous.

2. I understand that Dr. __________________________ is expected to perform some parts of the procedure, including but not limited to:

   - ☐ Opening and/or closing of the surgical site
   - ☐ Harvesting of grafts
   - ☐ Dissecting (cutting) tissue, organ or bone
   - ☐ Removing tissue, organ or bone
   - ☐ Inserting a medical device
   - ☐ Altering tissues
   - ☐ Other (describe) _______________________

3. Dr. _____________ has fully explained to me the purpose of the operation(s)/procedure(s) and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, both during the procedure and the recuperation period, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of the alternatives to the proposed treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

4. I understand that during the course of the operation(s)/procedure(s) unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional operation(s)/procedure(s) that the above-named physicians may consider necessary.

5. Any organs or tissues surgically removed may be examined and retained by the hospital for medical, scientific or educational purposes and such tissues or parts may be disposed of in accordance with customary practices.

6. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the operation(s)/procedure(s).

7. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above that do not pertain to me.

______________________________	___________________________	____________________
Patient/Relative/Guardian*	Print Name	Date/Time
______________________________		
Relationship to Patient		
______________________________	___________________________	____________________
Interpreter (if required)	Print Name	Date/Time
______________________________	___________________________	____________________
Witness	Print Name	Date/Time

* The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks) the proposed operation(s)/ procedure(s). I have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

______________________________	___________________________	____________________
Physician's Signature	Print Name	Date/Time

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.