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 operation(s) 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 and agree that the following individual(s) may perform some tasks or parts of the procedure.
   - ☐ Dr. ____
   - ☐ A qualified resident physician, under the supervision of the above physician(s).
   - ☐ A qualified non-physician (nurse practitioner, certified nurse midwife, or physician assistant).
3. The tasks this individual is expected to perform include, but are 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
   - ☐ Transplanting tissue
   - ☐ Altering tissues
   - ☐ Placing an invasive line
   - ☐ Other (describe) ________________________
4. 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.
5. 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.
6. 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.
7. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the operation(s)/procedure(s).
8. 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.