Consent For Procedure - FMC

I hereby authorize Dr.______________________________________ and/or such assistants as may be selected by him/her, to treat the condition or conditions which appear indicated by the diagnostic studies already performed.

Procedure or procedures to be performed:

I understand and agree that in certain situations it may be necessary for an associate of the physician listed above to assist the listed physician in the procedure or to perform procedure in the absence of the listed physician.

My doctor has explained to me the type, nature and extent of the procedure and the potential benefits, risks and side effects of the procedure(s) to be performed. I have also received from my doctor a fair explanation of reasonable alternatives to the proposed procedure(s) and the potential benefits, risks and side effects of those alternatives, The risks of not having the procedure or alternative, the likelihood that my goals for treatment will be met, and potential problems that may occur during recuperation have also been discussed.

It also has been explained to me, and I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees or promises have been made to me concerning the results of the operation, procedure or treatment.

It has been explained to me that during the course of the operation, unforeseen conditions may be revealed that necessitate the extension of the original procedure(s) other than those explained to me by my said doctor. I, therefore, authorize and request that my said doctor, his/her assistants or his/her designee perform such surgical procedures as are necessary and desirable in the exercise of his/her or their professional judgement and do hereby grant authority to my doctors to treat all conditions which may require treatment, although such conditions may not be discovered until after the operation or procedure is commenced.

I ☐ **CONSENT** / ☐ **DO NOT CONSENT** for the above procedure(s) to be photographed/video recorded. I understand I will not be identified in the photographs or video recordings.

I further ☐ **CONSENT** / ☐ **DO NOT CONSENT** to the disposal of any tissue or foreign body removed in the course of such procedure by incineration or otherwise, and consent to the microscopic or pathological examination thereof.

CONSENT FOR BLOOD ADMINISTRATION: I ☐ **CONSENT** / ☐ **DO NOT CONSENT** to accept the Blood/Blood Component Transfusions recommended by my physician. The nature and purpose of Blood/Blood Components, the risks involved and the possibility of complications have been explained to me. I understand that among these risks is the transmission of diseases that are carried by blood (such as AIDS and hepatitis), as well as any transfusion reactions, and I accept these risks. I hereby release my physician, the DCH Health System, and its employees from any liability involved in administering these Blood/Blood Component Transfusions. Further, I release my physician, the DCH Health System and its employees from any liability arising from the blood received or any component thereof.

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Signature of Patient | Date/Time

Patient is unable to sign and I, the undersigned, as his or her nearest relative or legal guardian, have signed the foregoing consent for the patient, believing this to be in the best interest of the patient and for the purpose of inducing the physician to perform the operation or procedure(s) authorized therein.

Signature of Relative or Legal Guardian | Date/Time | Relationship

Witness to either signature above | Date/Time

Second Witness for phone consent | Date/Time

DCH Health System®

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