

**HUNTINGTON HOSPITAL
CONSENT FOR OPERATION or PROCEDURE**

Name: _____
DOB: _____ Age: _____ Sex: _____
Acct#: _____ Religion: _____
MR#: _____
Attending MD: _____

1. I hereby authorize Dr. _____ and his/her assistants Dr. _____
to perform upon _____ the following operation or procedure:

Including such photographing, videotaping, television or other observation of the operation (s)/procedures(s) as may be purposeful for the advancement of medical knowledge and/or education, with the understanding that my/the patient's identity will remain anonymous and that all photographs and video tapes remain the property of the Hospital and physician.

2. I have been fully informed of the purpose, expected benefits, and potential complications of the operation or procedure. Alternatives to the planned operation or procedure, including the choice of no treatment, have been explained to me. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
3. I understand that during the course of the operation or procedure unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional operations or procedures, which the above-named physician or his/her assistants may consider necessary.
4. I further consent to the administration of any anesthetics that may be needed. I recognize that there are always risks to health and life associated with anesthesia.
5. I have been informed and give consent for the manufacturer's technical support representative(s) [a non-hospital employee], as necessary or advisable, to be present during the procedure.
6. Any tissues or parts surgically removed may be disposed of by the hospital in accordance with accustomed practices. Reasonable requests as to disposal made by the patient or his/her representative will be given due consideration in accordance with CDC, OSHA and Infection Control Laws and Regulations.
7. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the operation or procedures.
8. Should the need arise during my operation or immediate post-operative period, I also consent to the administration of blood and/or blood products. Further, I understand that despite careful testing and screening of blood and blood products by collecting agencies, I may still be subject to ill effects as a result of receiving a blood transfusion and /or blood products. The following are some of the possible benefits of transfusion: restores blood and oxygen carrying capacity lost through bleeding or due to anemia, prevents serious illness or death due to blood loss. Blood products; i.e., fresh frozen plasma, platelets, cryoprecipitate, may help to restore normal blood clotting. The following are some, but not all, of the potential risks that I am told can occur; fever and allergic reactions, hemolytic reactions, transmission of diseases such as Hepatitis, AIDS, and cytomegalovirus (CMV) and fluid overload.
9. 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 that do not pertain to me.
10. I authorize Huntington Hospital to release my Social Security number to the manufacturer of any medical device(s) I receive. I understand that my Social Security number is used only to locate or contact me if there is a need with regard to the medical device. I release Huntington Hospital, its governing body, officers, directors, agents, appointees, employees, students and medical staff from any liability that might result from the release of this information. Patient Refused (Please check box)

Patient Signature: _____ Date: _____ Time: _____

Relative/Guardian Signature: _____ Relationship: _____

Witness Signature: _____ Print Name: _____

Interpreter Signature: _____ Print Name: _____

REFUSAL OF BLOOD PRODUCTS. I refuse transfusion of packed red cells, platelets, plasma or white blood cells even if such refusal may result in my death _____

(Patient signature)



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6/11

